MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

34086

1. PLACE OF DEATH
County Jackson — Registration District No. 402
Township Sniabar — Primary Registration District No. 5357 B.
City ..... (No. ..... St. ..... Ward)

File No. .....
Registered No. 19

2. FULL NAME Joseph Marion Wyatt
(a) Residence. No. ..... St. ..... Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sarah Wyatt

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr. 18 - 1844

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	85	6	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer —

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Kentucky

PARENTS
10. NAME OF FATHER Kristenden Wyatt
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ky.
12. MAIDEN NAME OF MOTHER Winifred Duncan
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ky

14. INFORMANT Fred Wyatt
(Address) Oak Grove Mo.

15. FILED 10/23 1929 A W Mann
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/22 1929

17. I HEREBY CERTIFY, That I attended deceased from Oct. 10 — 1929, to Oct. 21 — 1929 that I last saw him alive on Oct. 21 — 1929, and that death occurred, on the date stated above, at 9.45 — a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Nephritis
131
97
(duration) 10 - yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Arterio-sclerosis
(duration) 10 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) A W Mann, M. D.
10/23, 1929 (Address) Oak Grove, Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Buckner Mo.	10/23 1929
20. UNDERTAKER L. D. Webb Oak	ADDRESS Grove Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD

NOV 2 1929

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