

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

APR 12 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9616

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1050

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 2849 Forest
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 25 years (Specify whether years, months or days)
 In this community 25 years

8. (a) PRINT FULL NAME CORNELIUS J. WYBLE 140

8. (b) If veteran, name war No 8. (c) Social Security No. No

4. Sex Male 5. Color or race Wh 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs. Eva Wyble 6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased June 29 1880
(Month) (Day) (Year)

8. AGE: Years 59 Months 8 Days 5 If less than one day hr. min.

9. Birthplace Eaton Michigan
(City, town, or county) (State or foreign country)

10. Usual occupation City Employee Park Board

11. Industry or business Park Board

MOTHER FATHER { 12. Name William Wyble

13. Birthplace Michigan
(City, town, or county) (State or foreign country)

14. Maiden name Mary E. Clark

15. Birthplace Michigan
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature William Wyble
 (b) Address 2849 Forest

17. (a) Burial (b) Date thereof Mar. 6-40
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Mt. Washington Cem.

18. (a) Signature of funeral director J. W. Wagner
 (b) Address Kansas City, Mo.

19. (a) Mch 6, 1940 (b) M. M. Browne
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL")
 (d) Street No. 2849 Forest
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 4th
 year 1940 hour 3 minute 30 P. M.

21. I hereby certify that I attended the deceased from _____, 19____; to _____, 19____; that he/she was alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Hemopericardium

Ruptured dissecting aneurysm of the aorta

Duration Chronic aortitis 9/6

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Victor B. Duhon (M. D. or other) _____
 Address K. C. Mo. Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Cecil R Matthis

Licensed Embalmer No. 3807

P. O. Address 250 Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.