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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

33741

FILED NOV 25 1940

State File No. _____

Registration District No. _____

Primary Registration District No. 4305

Registrar's No. 34

1. PLACE OF DEATH:
 (a) County Linn
 (b) City or town Marceline
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Putman Memorial
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 4 Days
(Specify whether
 In this community Two weeks
years, months or days)

3. (a) PRINT FULL NAME Joseph Baker Wyett
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced. Widowed
 6. (b) Name of husband or wife Wife 6. (c) Age of husband or wife if alive _____ years
Ora Belle Wyett
 7. Birth date of deceased Nov. 30, 1860
(Month) (Day) (Year)

8. AGE: Years 79 Months 10 Days 29 If less than one day
hr. min.

9. Birthplace Linn Co, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Watchman

11. Industry or business R.R.

12. Name Sampson Wyett

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

14. Maiden name Emily Ryan

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

16. (a) Informant Mrs Charles Lepshere

(b) Address 510 Smith St. Brookfield

17. (a) Burial (b) Date thereof 10.30/1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wyandott, Mo.

18. (a) Signature of funeral director M. J. Shaene
Laclede, Mo.

(b) Address _____
 19. (a) 10-29-40 (b) Oliver Barrett
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Ore. (b) County _____
 (c) City or town Portland
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 29
 year 1940 hour 5 minute 30 4 M.

21. I hereby certify that I attended the deceased from Oct 10
 _____, 1940, to Oct 29, 1940;
 that I last saw him alive on Oct 28, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Chronic Degenerative Myocarditis (?)

Due to Hypertension

Due to _____
 Other conditions Asthma
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

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

23. Signature M. L. DeGraeger (M. D. or other) M. D.
 Address Marceline Mo Date signed 10/29/40

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

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 Me

W.G. Thorne

Registered Apprentice No. 2876

working under my personal supervision.

Signed


W.G. Thorne

Licensed Embalmer No. 2876

P. O. Address Laclede, Mo.

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

If this body is not embalmed, fact should be so stated above.