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FILED MAY 13 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

16170

State File No. \_\_\_\_\_

Registration District No. 882

Primary Registration District No. 6174

Registrar's No. 6

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

1. PLACE OF DEATH: Warren  
 (a) County Warren  
 (b) City or town Wright City Rural  
 (c) Name of hospital or institution: (Pittsburg House)  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 In this community 40 years. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo (b) County Warren  
 (c) City or town Wright City Rural  
 (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.? 0 years.

3. (a) PRINT FULL NAME Adeline Wyatt  
 (b) If veteran, name war 3  
 (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month May day 5th year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from Nov-8- 1940 to \_\_\_\_\_ 1941;  
 that I last saw her alive on April 23, 1941;  
 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race Negro  
 6. (a) Single, widowed, married, divorced Widowed  
 6. (b) Name of husband or wife Calvin Wyatt  
 6. (c) Age of husband or wife if alive 48 years  
 7. Birth date of deceased Oct - 1861  
 (Month) (Day) (Year)

Immediate cause of death: Pneumonia (hypostatic)  
 Due to circulatory failure + moribund  
 Due to chronic indolent fever  
 Other conditions (include pregnancy within 3 months of death) 5

8. AGE: Years 79 Months 9 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

9. Birthplace Warrenton Mo  
 (City, town, or county) (State or foreign country)  
 10. Usual occupation House duties

11. Industry or business \_\_\_\_\_  
 12. Name Peter Ball  
 13. Birthplace Don't know 9  
 (City, town, or county) (State or foreign country)  
 14. Maiden name \_\_\_\_\_  
 15. Birthplace \_\_\_\_\_ 9  
 (City, town, or county) (State or foreign country)

16. (a) Informant Bessie Robinson  
 (b) Address Wright City, Mo  
 17. (a) Burial (b) Date thereof 5/7/41  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Wright City  
 18. (a) Signature of funeral director T. Pittsburg  
 (b) Address Wrightville, Mo  
 19. (a) 5/6/41 (b) Jelma Deburg  
 (Date received local registrar) (Registrar's signature)

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? 902  
 (Specify type of place) \_\_\_\_\_  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
 23. Signature Geo H Gronow M.D.  
 Address Wright city mo Date signed 5/6/41

**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.....

*J. C. Stewart*

Licensed Embalmer No. 270

P. O. Address.....

*Wentzville, 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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 16170

Registration District No. 882

Primary Registration District No. 6174

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Warren  
(b) City or town Hickory Grove Twp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Adelme Wyatt  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month May day 5  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex 7 5. Color Black 6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
alive 1861 year  
7. Birth date of deceased: Oct 1861  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

8. AGE: Years 79 Months 7 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

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 \_\_\_\_\_

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_  
17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)  
(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_  
19. (a) 5/6/41 (b) Julius Nieburg  
(Date received local registrar) (Registrar's signature)

23. Signature Wright City, Mo (M.D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTAL COPY

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

