

No. 2  
1-4-41  
1-17-39  
X28320

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

24363

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

**RID AUG 16 1941**  
Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. 2902

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:  
Trinity Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 48 Hours  
(Specify whether years, months or days)

In this community 2 Years 0 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 142

(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")

(d) Street No. 3631 Baltimore  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Tressie Evelyn Wyatt

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive None years

7. Birth date of deceased August 7, 1919  
(Month) (Day) (Year)

8. AGE: Years 21 Months 10 Days 24 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Cameo Beauty Shop

11. Industry or business Hair Dresser

12. Name Branson Wyatt

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

14. Maiden name Mellie Moore

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

16. (a) Informant Mr. Herbert W. Williams

(b) Address 3631 Baltimore

17. (a) Removal (b) Date thereof 7/31/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Prinston, Missouri

18. (a) Signature of funeral director Mrs. L. Forster

(b) Address 918 Brooklyn

19. (a) 7-31-41 (b) M. M. Groome  
(Date received local registrar) (Registrar's signature)

261 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31  
year 1941 hour 8 minute 59 M.

21. I hereby certify that I attended the deceased March 3 1941 to July 31 1941  
that I last saw her alive on July 31 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Generalized peritonitis 24 hrs  
Due to Tubo-Ovarian Abscess 3 mo.

Due to Pelvic inflammatory disease 1  
Other conditions \_\_\_\_\_

Major findings: Right tubo-ovarian abscess ruptured  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration  
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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) Means of injury \_\_\_\_\_  
23. Signature Shirley W. ... M. D. or other \_\_\_\_\_  
Address 925 Argyle Bldg Date signed 7/31/41

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

MOTHER FATHER

**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  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed J. Edwin Shepherd  
.....  
Licensed Embalmer No. 4179  
.....  
P. O. Address K.C. 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. 24363

Registrar's No. 2902

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Panama City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution Trinity Hosp.  
(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)

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

4. Sex 2 5. Color or race W 6. (a) Single, widowed, married, divorced 5  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Aug 7-1919  
(Month) (Day) (Year)

8. AGE: Years 21 Months 11 Days 24 If less than one year \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Mo  
(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)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

GENERAL CERTIFICATION

20. DATE OF DEATH: Months July day 31  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Due to Tubo-Ovarian Abscess

Due to Gonorrheal pelvic inflammatory disease

Other conditions \_\_\_\_\_  
(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? \_\_\_\_\_

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

23. Signature Charles Henry M.D. or other \_\_\_\_\_

Address 925 Arroyo Date signed 1/30/44

SUPPLEMENTAL

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

MOTHER FATHER

