

FILED FEB 11 1942

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

2784

Do not use this space.

1. PLACE OF DEATH

(a) County Mc Donald Registration District No. 963 22
 (b) Township Elk River Primary Registration District No. 5692 Registered No. 222-44
 (c) City HOET (d) Street No. 1 St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Oliver H. Wylie

(a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Carrie Wylie

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 25 1868

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
73 1 6

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. W. P. A. Labor
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa

FATHER 13. NAME Andrew Wylie

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

MOTHER 15. MAIDEN NAME Lucy Cummings

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) North Carolina

17. INFORMANT (ADDRESS) Rivers Wylie
Noel, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE NOEL MO. DATE Jan, 2 42

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wm. M. Payne
Wheaton, Mo.

20. FILED 1-2 19 42 C. Alvarado
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 31 1941

22. I HEREBY CERTIFY, That I attended deceased from July 11, 1941, to Dec 31, 1941
 I last saw him alive on Dec 30, 1941. Death is said to have occurred on the date stated above, at 7 P. m.
 The principal cause of death and related causes of importance were as follows:

Fractured hipDate of onset
July 11

Other contributory causes of importance:

Septic Bed Sores
SenilityOct 19
1941Name of operation Date of What test confirmed diagnosis? X-ray Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury , 19 Where did injury occur? (Specify city or town, county, and State)Specify whether injury occurred in industry, in home, or in public place. Manner of injury Nature of injury 24. Was disease or injury in any way related to occupation of deceased? NoIf so, specify (Signed) O. A. Learning, M. D.(Address) Noel Mo

(Licensed Embalmer's Statement on Reverse Side)

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

50M-3-10-38 I X16405

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.

RECEIVED

District Health Officer No. 6;

District File Number 242-164

Date Filed FEB 6 1942

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

Wm. Mervin Pogue

Licensed Embalmer No.

3442

P. O. Address

Wheaton 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.

Registration District No. **963**

Primary Registration District No. **5692**

Registrar's No. _____

1. PLACE OF DEATH: **McDonald**
 (a) County _____
 (b) City or town _____
 (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

3. (a) PRINT FULL NAME **Olever H. Wylie**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Nov. 25 1868**
 (Month) (Day) (Year)

8. AGE: Years **73** Months **1** Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry of 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 _____ (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him/her alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

fracture hip.

Due to _____

Due to _____

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

Major findings: **186 a**
Of operations **18**

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 **July 10 1941**

(c) Where did injury occur? **on street near his home** (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **Yes**

(Specify type of place)

While at work? **No** (e) Means of injury **specify**

23. Signature **J.A. Gearing** (M. D. or other) _____

Address **noel mo** Date signed **Jan 3 1942**

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

SUPPLEMENTARY

5-2784