

S. No. 2
M-9-4-41
v. 5-17-39
I X29284

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **9433**
Registrar's No. **2913**

FILED APR 13 1942 91
Registration District No. **7**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County St. Louis, Missouri
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Christian Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 weeks
(Specify whether years, months or days)
In this community 2 weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 0 22
(c) City or town Clarksville NR
(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 1

3. (a) PRINT FULL NAME Sallie Wyatt
(b) If veteran, name war _____
(c) Social Security No. None

20. DATE OF DEATH: Month March day 31
year 1942 hour 3 minute 45A M.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widow
(b) Name of husband or wife Augustus Wyatt
(c) Age of husband or wife if alive _____ years
7. Birth date of deceased August 1, 1867
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 22 1942 to March 31 1942
that I last saw her alive on March 31 1942
and that death occurred on the date and hour stated above

8. AGE: Years Months Days If less than one day
74 7 29 hr. _____ min.

Immediate cause of death obstruction (due to adhesions)
Duration 4 days
Due to adhesions of 122 ft

9. Birthplace Clarksville Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Housework
11. Industry or business _____

Other conditions Cholecystitis Indefinite Non-calculous
Major findings: Obstruction of Small Intestine; adhesions Cholecystitis
Of operations _____
Of autopsy None

MOTHER FATHER {
12. Name Thomas Cothron
13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Tott
15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)
16. (a) Informant Diego Wyatt
(b) Address Clarksville, Missouri
17. (a) Burial (b) Date thereof 3/31/42
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Clarksville, Mo
18. (a) Signature of funeral director Albert H. Hoppe Inc
(b) Address 4700 Washington Blvd.
19. (a) MAR 31 1942 (b) J. F. Breda
(Date received local registrar) (Registrar's signature)

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 Diego Wyatt (M. D. or other) _____
Address Clarksville, Mo Date signed 3/24/42

MAR 30 1948

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.....

Walter G. Koffe

Licensed Embalmer No..... *2991*

P. O. Address.....

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.