

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

Registration District No. **200**

Primary Registration District No. **6225**

1. PLACE OF DEATH:

(a) County **VERNON**  
(b) City or town **NEVADA**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **STATE HOSPITAL NO. 3**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **10 DAYS**  
(Specify whether years, months or days) **10 DAYS**

3. (a) PRINT FULL NAME **HENRY WYMUTH, SR**  
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 **WID**  
6. (b) Name of husband or wife **DECEASED** (c) Age of husband or wife if alive **—** years  
7. Birth date of deceased **Oct 13 1858**  
(Month) (Day) (Year)

8. AGE: Years **85** Months **1** Days **—** If less than one day hr. min.

9. Birthplace **BENTON CO MO** (City, town, or county) (State or foreign country)  
10. Usual occupation **NOT EMPLOYED**

MOTHER FATHER

11. Industry or business  
12. Name **GEORGE WYMUTH**  
13. Birthplace **GERMANY** (City, town, or county) (State or foreign country)  
14. Maiden name **UNKNOWN**  
15. Birthplace **9** (City, town, or county) (State or foreign country)

16. (a) Informant **HENRY L. WYMUTH JR**  
(b) Address **COLE CAMP MO**  
17. (a)  Burial, cremation, or removal (b) Date thereof **11-13-43**  
(Month) (Day) (Year)  
(c) Place: burial or cremation **Cole Camp Mo**  
18. (a) Signature of funeral director **Fred J. Jones**  
(b) Address **Nebraska Mo**  
19. (a) **11-13-43** (Date received local registrar) (b) **Boyd B. Beurch** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Benton**  
(c) City or town **COLE CAMP**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **—**  
(If rural, give location)  
(e) Citizen of foreign country? **YES** (Yes or No)  
If yes, name country **BENTON CO I**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **NOV** day **13**  
year **1943** hour **2** minute **40** P.M.  
21. I hereby certify that I attended the deceased from **NOV 3 1943**  
**NOV 3 1943** to **NOV 13 1943**  
that I last saw him alive on **NOV 13 1943**  
and that death occurred on the date and hour stated above.  
Immediate cause of death **SENILE DEMENTIA** Duration **—**

Due to **GENERALIZED ARTERIO SCLEROSIS**

Due to **—**  
Other conditions (Include pregnancy within 3 months of death) **—**

Major findings: Of operations **0**  
Of autopsy **20**

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?  
23. Signature **R. E. Hall** (M. D. or other) (Specify type of place) (e) Means of injury **—**  
Address **Nebraska Mo** Date signed **11-13-43**

RECEIVED

District Health Officer No. 71

District File Number 11-43-1301

Date Filed 12-6-43

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**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 W E Ferry

Licensed Embalmer No. 1432

P. O. Address Nevada 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.**

Registration District No. 360 Primary Registration District No. 6225

1. PLACE OF DEATH:  
(a) County Vernon  
(b) City or town Rural: Washington Twp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: State Hospital # 3  
(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 Henry Wymuth Sr  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov Day 13 Year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

4. Sex m 5. Color or race w  
6. (a) Single, widowed, married, divorced w  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ year \_\_\_\_\_ min.  
7. Birth date of deceased: oct 13 1885  
(Month) (Day) (Year)

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

8. AGE: Years 85 Months \_\_\_\_\_ Days \_\_\_\_\_  
If less than one day \_\_\_\_\_ min.  
9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

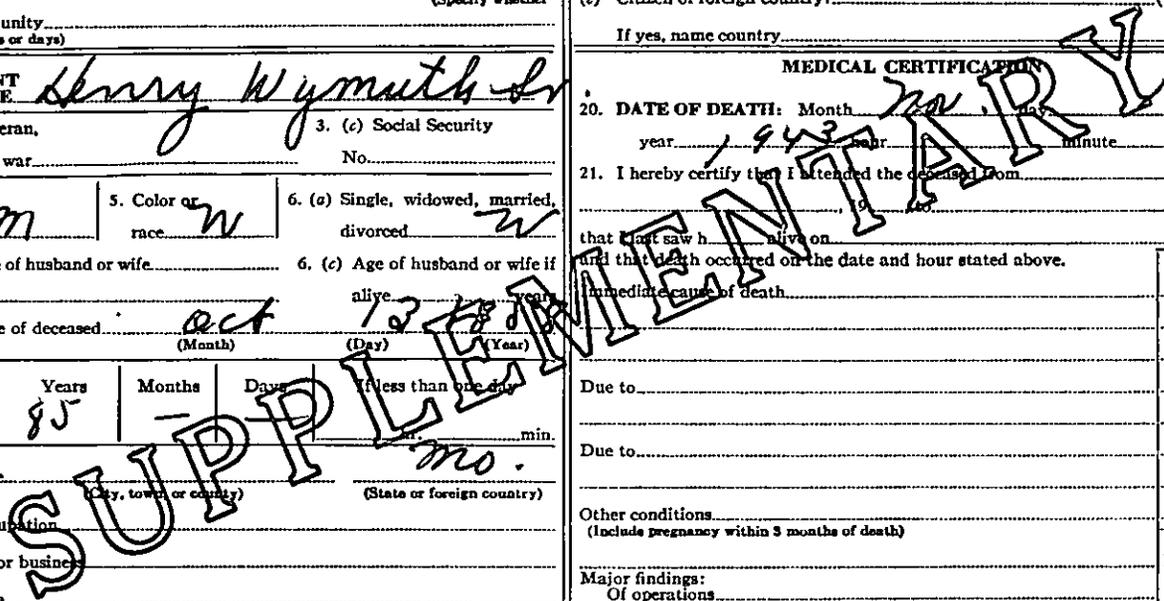
22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

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)

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

MOTHER FATHER }  
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) \_\_\_\_\_ (b) Angel B. Burch  
(Date received local registrar) (Registrar's signature)

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



Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

S-3939D