

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

39
36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 10 1944
Registration District No. 365

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
Primary Registration District No. 0240

State File No. 16066
Registrar's No. 11

1. PLACE OF DEATH:
(a) County Washington
(b) City or town Rural Hammon Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Jimmie Ray Pyatt
3. (b) If veteran _____ (c) Social Security name war _____ No. _____

4. Sex M. Color or trace W
6. (a) Single, widowed, married, divorced, child
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years (Month) (Day) (Year)
7. Birth date of deceased Nov 13 1941
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 5 26 hr. _____ min.

9. Birthplace Washington Co Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name Earnest L. Pyatt
13. Birthplace Washington Co Mo. 0
(City, town, or county) (State or foreign country)
14. Maiden name Lena Whitaker
15. Birthplace Crawford Co Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Earnest L. Pyatt
(b) Address Idmael Mo.

17. (a) Burial (b) Date thereof April 10 44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Gar Mo.

18. (a) Signature of funeral director E. L. Sparks
(b) Address Potosi Mo.

19. (a) AP-27-44 (b) Edna White
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Washington
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. East of railroad past office
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 9
year 1944 hour 12 minute P. M.

21. I hereby certify that I attended the deceased from April 8 1944 to April 9 1944
that I last saw him alive on on April 9 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Osteomyelitis
Left ankle
following scald
wound of leg
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____

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)
(c) Means of injury fall
23. Signature E. L. Sparks (M. D. or D. O.)
Address Potosi Date signed 4/10/44

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

810

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 544-3800

Date Filed 5-9-44

not embalmed

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 D. L. Sparks

..... Licensed Embalmer No.....

P. O. Address Patuxent ma

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. 260

Primary Registration District No. 6240

1. PLACE OF DEATH:

(a) County Washington
(b) City or town Rural Harmony
(If outside city or town limits, write "RURAL" and name of township) Jeff
(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 (Specify whether _____)

3. (a) PRINT FULL NAME James R. Pyatt

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 _____

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

7. Birth date of deceased mo (Month) 12 (Day) 1944 (Year)

8. AGE: Years 1 Months _____ Days _____ (If less than one day, _____ min.)

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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)
(Burial, cremation, or removal) _____
(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 April Day 19
Year 1944 Hour _____ minute _____ M.

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

Immediate cause of death Staphylococcus Hemorrhagicus Ostromyelitis!
Due to _____
Due to _____

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

Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) no
(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 H. F. Stesswell (M. D. optional) 11/14/44
Address Polart, Mo. Date signed _____

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

SUPPLEMENTARY

BUREAU OF

1944 MAY 17 PM

ADMINISTRATIVE SERVICES
DIVISION

100006