

FILED JUL 10 1944

Registration District No. _____

Primary Registration District No. 4009

Registrar's No. 58

1. PLACE OF DEATH:

- (a) County Andrew 2
- (b) City or town Savannah
(If outside city or town limits, write "RURAL" and name of township)
- (c) Name of hospital or institution
Dr. Nichols Sanatorium
(If not in hospital or institution, write street number or location)
- (d) Length of stay: In hospital or institution 12 days
(Specify whether years, months or days)
- In this community 12 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME CHARLES MILTON WYANT

8. (b) If veteran, name war L
8. (c) Social Security No. L

4. Sex male
5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 6 1883
(Month) (Day) (Year)

8. AGE: Years 61 Months 20 If less than one day hr. _____ min. _____

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

10. Usual occupation Unknown

11. Industry or business _____

12. Name Unknown
13. Birthplace _____
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
(City, town, or county) (State or foreign country)
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Hospital Records
- (b) Address Savannah Mo.
17. (a) Removal (b) Date thereof 6-27-1944
(Burial, cremation, or removal) (Month) (Day) (Year)
- (c) Place: burial or cremation Eureka Kansas
18. (a) Signature of funeral director Walter Medersbacher
- (b) Address 1301 Garson St. St. Joseph Mo.
19. (a) 6-27-44 (b) F. H. Fitchman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Colorado (b) County ✓ 911
5
U
- (c) City or town Denver 6
(If outside city or town limits, write "RURAL")
- (d) Street No. 1363 Vine
(If rural, give location)
- (e) If foreign born, how long in U. S. A.? 2 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 26
year 1944 hour 12¹⁰ minute 10 P. M.

21. I hereby certify that I attended the deceased from June 14
1944, to June 26, 1944
that I last saw him alive on June 26, 1944
and that death occurred on the day and hour stated above.

- Immediate cause of death failure compensation
of heart following hemorrhage
of facial artery
Due to removal of retractor
of lower lip and removal
Due to enlarged lymphatic
glands under jaw
- 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 J. O. Manning (M. D. or other) _____
Address Savannah Mo. Date signed 6/26/44

JUL 13 1944

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 *Albert C. Harrington*

Licensed Embalmer No. *3258*

P. O. Address *St. Joseph, 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.

2
43
39
37823

Registration District No. 2

Primary Registration District No. 4009

Registrar's No. 58

1. PLACE OF DEATH:

(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 _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Colorado (b) County Denver
(c) City or town Denver
(If outside city or town limits, write "RURAL")
(d) Street No. 1363 Pine
(If rural, give location)
(e) Citizen of foreign country? ✓ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CHARLES MILTON WYANT

3. (b) If veteran, name war No 3. (c) Social Security No. _____

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife PAULINE L. WYANT 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased JUNE 1833
(Month) (Day) (Year)

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

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

10. Usual occupation PLUMBER

11. Industry or business GENERAL PLUMBING

12. Name CHARLES M. WYANT

13. Birthplace RICHMOND OHIO
(City, town, or county) (State or foreign country)

14. Maiden name SARAH C. ROBERTSON

15. Birthplace BIRLEVILLE OHIO
(City, town, or county) (State or foreign country)

16. (a) Informant Z. E. WYANT

(b) Address 1613 TOPEKA BLVD. TOPEKA ARMS

17. (a) REMOVAL (b) Date thereof 6-27-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation EUREKA ARMS

18. (a) Signature of funeral director Walter Meierhoffer

(b) Address St. Joseph, Mo.

19. (a) 7-10-44 (b) J. A. Britchman
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

DATE OF DEATH: Month June day 26th
year 1944 hour 12:10 minute P. M.

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

Immediate cause of death _____
Duration _____

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) _____
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 _____ (M. D. or other) _____

Address _____ Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

20992

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.....

Licensed Embalmer No.....

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.