

Registration District No. **318**

Primary Registration District No. **1003**

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: Homer G. Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 10 days  
In this community 52 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3135 Laclede  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Anne Wyatt

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex female 5. Color or race negro 6. (a) Single, widowed, married, divorced widow

6. (b) Name of husband or wife Dead 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased JUNE 22<sup>nd</sup> 1876  
(Month) (Day) (Year)

8. AGE: Years 68 Months 4 Days 3 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation housework

11. Industry or business at home

12. Name GEORGE WYATT

13. Birthplace LOUISIANA MISSOURI  
(City, town, or county) (State or foreign country)

14. Maiden name HATTIE PORTER

15. Birthplace LOUISIANA MISSOURI  
(City, town, or county) (State or foreign country)

16. (a) Informant Clara Watkins

(b) Address 3135 Laclede ave

17. (a) Burial (b) Date thereof 10/29/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wright City Mo.

18. (a) Signature of funeral director C.W. Roberts

(b) Address 1416 N. Taylor ave

19. (a) OCT 26 1944 (b) Hebradech  
(Date of local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 23,  
year 1944 hour 1 minute 00 A. M.

21. I hereby certify that I attended the deceased from October 13, 1944, to October 23, 1944,  
that I last saw her alive on October 23, 1944,  
and that death occurred on the date and hour stated above.

Immediate cause of death Generalized peritonitis Duration 2 days

Due to Appendiceal Abscess 10 days

Due to 12/1/2  
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) (e) Means of injury \_\_\_\_\_

23. Signature H. Brewer (M. D. number) \_\_\_\_\_

Address 2601 N. Shiloh Date signed 10/24/44

Duration  
2 days  
10 days  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

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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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed Fuller E. Calkin

Licensed Embalmer No. 4198

P. O. Address Stennis 13 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.**