

FILED DEC 27 1944
318

Registration District No. _____

Primary Registration District No. _____

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

1. PLACE OF DEATH:

(a) County St Louis, Mo.
(b) City or town St Louis,
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Peoples Hospital, 2221 Locust, Ave
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (17) Days
(40) Years, 0 (Specify whether
In this community years, months or days)

3. (a) PRINT FULL NAME Joseph B, Wayatt.

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

4. Sex Male 5. Color or race colored 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Angie Bell Wyatt, deceased. 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased. June 13th 1877.
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
<u>67</u>	<u>6</u>	<u>XXX</u>	hr. _____ min.

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

10. Usual occupation Maintenance-man,
11. Industry or business Police Dept, City Of St Louis.

MOTHER FATHER
12. Name George Wyatt,
13. Birthplace Memphis, Tenn.
(City, town, or county) (State or foreign country)
14. Maiden name Fannie Dent.
15. Birthplace Memphis, Tenn.
(City, town, or county) (State or foreign country)

16. (a) Informant Harvey Wyatt
(b) Address Kinloch, Mo.

17. (a) Burial (b) Date thereof 12/16/44.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem'ry

18. (a) Signature of funeral director [Signature]
(b) Address 3615 [Address]

19. (a) DEC 15 1944 (b) [Signature]
(Date received local registration) (Registrar's signature)

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. 2632A Bellglade,
(If rural, give location)
(e) Citizen of foreign country? Both U.S. OF A. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December 13th
1944. year. hour _____ minute 14. M.

21. I hereby certify that I attended the deceased from 11/19, 1944 to 12/13, 1944
that I last saw him alive on Dec/13 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma Stomach
Duration _____

Due to Carcinoma 1945

Due to _____

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

Major findings: NONE
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?
(Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address 822 W. Jefferson Date signed 12/14/44

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. *myself*

Signed..... *A. J. Hunt*

Licensed Embalmer No. *2265*

P. O. Address *2912, Thomas St. Louisville*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **39872**

Registration District No. _____

Primary Registration District No. _____

Registrar's No. **10681**

1. PLACE OF DEATH:

(a) County St Louis
 (b) City or town St Louis
 (c) Name of hospital or institution: Peoples Hospital
 (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)

3. (a) PRINT FULL NAME

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

4. Sex Male 5. Color Col 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 67 Months 6 Days XX If less than one day _____ hr. _____ min.

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

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)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) JAN 18 1945 (b) J. F. Brudek
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Louis
 (c) City or town St Louis
 (d) Street No. 2632nd Belleglade
 (If rural, give location)
 (e) Citizen of foreign country _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec, day 13
 year _____ hour _____ minute _____ 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 _____

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)
 (e) Means of injury _____

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

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

MOTHER FATHER

1944
S-39892