

FILED AUG 5 1946

Registration District No. 323

Primary Registration District No. 4474

Registrar's No. 72

1. PLACE OF DEATH:

(a) County SALINE  
(b) City or town SWEET SPRINGS  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 207 S. Locust 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 34 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County SALINE 99  
(c) City or town SWEET SPRINGS 3  
(If outside city or town limits, write "RURAL")  
(d) Street No. 207 S. Locust 0  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23,  
year 1946 hour 4 minute 08 P.M.  
21. I hereby certify that I attended the deceased from June 1945  
\_\_\_\_\_ 19\_\_\_\_ to July 23, 1946;  
that I last saw him alive on July 18, 1946;  
and that death occurred on the date and hour stated above.

Immediate cause of death Senility Duration \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy 1628

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) Means of injury \_\_\_\_\_  
23. Signature Chas R Paurom (M. D. or other) M.D.  
Address Sweet Springs Mo Date signed July 24 46

3. (a) PRINT FULL NAME JESSE EDW. WYLLIE  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED  
7. Birth date of deceased: JUNE (Month) 9 (Day) 1865 (Year)

8. AGE: Years 81 Months 1 Days 14 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace McCracken Co. Ky 1  
(City, town, or county) (State or foreign country)

10. Usual occupation MINISTER

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name DAVID NEGAL WYLLIE  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name MARY J WAS BURN  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant W.E. Wyllie

(b) Address Sweet Springs Mo

17. (a) Burial (b) Date thereof 7/25/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Truist Cemetery

18. (a) Signature of funeral director R.C. Carter

(b) Address Sweet Springs Mo

19. (a) 7/24/46 (b) Dolly Andrew  
(Date received local registrar) (Registrar's signature)

295

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

7  
030

24788

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 8-3-46

**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 *W. Carter*

Licensed Embalmer No. 35723

P. O. Address *West Virginia*

**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.**