

12-45
5-17-39
X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37258
Registrar's No. 4925

FILED DEC 9 1946
Registration District No. 199

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County WAGON

(b) City or town KANSAS CITY
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
2801 BROOKLYN AVE.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community 10 Mo.
years, months or days

3. (a) PRINT FULL NAME Michael Ray Wyatt

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male

5. Color or race negro

6. (a) Single, widowed, married, divorced, single

6. (b) Name of husband or wife _____

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

7. Birth date of deceased. JAN 11, 1946
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
—	<u>10</u>	<u>9</u>	— hr. — min.

9. Birthplace: KANSAS CITY, MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation infant

MOTHER FATHER

11. Industry or business _____

12. Name UNKNOWN

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

14. Maiden name LOVENIA WYATT

15. Birthplace PORT GIBSON MISSISSIPPI
(City, town, or county) (State or foreign country)

16. (a) Informant (MOTHER) LOVENIA WYATT

(b) Address 505 S. Juliette St. Manhattan Mo.

17. (a) Burial (Burial, cremation or removal) (b) Date thereof Nov. 26, 46
(Month) (Day) (Year)

(c) Place: burial or cremation Westlawn Cem. H

18. (a) Signature of funeral director C. E. Davis

(b) Address 1513 TROOST AVE., K.C.M.O.

19. (a) 11-26-46 (Date received local registrar)

(b) Staldine Holme (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County WAGON

(c) City or town KANSAS CITY
(If outside city or town limits, write "RURAL")

(d) Street No. 2801 BROOKLYN AVE.
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 20
year 46 hour 12 minute 45 A.M.

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

Immediate cause of death Cardiac Failure

Due to Broncho-Pneumonia

Due to _____

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

Major findings: 107

Of operations _____

Of autopsy No-Permit

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? C-K

While at work? _____ (Specify type of place)

(c) Means of injury Refrigerator

23. Signature W. Williams (M. D. or other) Comm

Address 2636 Brooklyn Date signed 11-22-46

Duration

1

24-hr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

C. C. Davis

Licensed Embalmer No. *4417*

P. O. Address *T. C. 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.