

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1847
Registrar's No. 13

FILED FEB 10 1947

Registration District No. 217

Primary Registration District No. 3045

1. PLACE OF DEATH:

(a) County Mississippi
(b) City or town Charleston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1002 E. Cypress St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community All of Life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi
(c) City or town Charleston
(If outside city or town limits, write "RURAL")
(d) Street No. 1002 E. Cypress St.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William A. Wyatt

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

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Violet Wyatt 6. (c) Age of husband or wife if alive 61 years
7. Birth date of deceased December 17, 1884
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>62</u>	<u>0</u>	<u>27</u>	hr. min.

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

10. Usual occupation Retired Public Officer

11. Industry or business None

12. Name William M. Wyatt

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

14. Maiden name Mae Parker

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

16. (a) Informant Carl Wyatt

(b) Address Charleston, Missouri

17. (a) Burial (b) Date thereof 1/16/1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation I.O.O.F. Cemetery, Charleston, Missouri

18. (a) Signature of funeral director [Signature]
(b) Address Charleston, Missouri

19. (a) 1-24-47 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 14th
year 1947 hour 9:30 minute _____ P. M.

21. I hereby certify that I attended the deceased from Jan 6, 1946 to Jan 15, 1947
that I last saw h. 107 live on Jan 15, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis
Due to _____

Other conditions Pulm Tuberculosis 1 year
(Include pregnancy within 3 months of death)

Major findings: no
Of operations no
Of autopsy no

Duration _____
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) (c) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address Charleston, Mo Date signed 1/22/47

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

MOTHER FATHER

196

RECEIVED

District Health Office No. 2

District File Number 147-158

Date Filed 1-30-47

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 John F. Nunnelee Jr
Licensed Embalmer No. 3851
P. O. Address Charleston, 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.