

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 17 1947
Registration District No. 288

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14129
Registrar's No. 175

Primary Registration District No. 3041

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

1. PLACE OF DEATH:
(a) County macon
(b) City or town macon
(c) Name of hospital or institution:
1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)

3. (a) PRINT FULL NAME J. E. Hyatt
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex males 5. Color or race White
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec 8 - 1861
(Month) (Day) (Year)

8. AGE: Years 85 Months 3 Days 5
If less than one day _____ hr. _____ min.

9. Birthplace Adams Co Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Doctor of Osteopathy

11. Industry or business _____

MOTHER FATHER

12. Name Elisha Hyatt

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

14. Maiden name Belinda Jennings
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs Wallace Wright
(b) Address macon

17. (a) burial (b) Date thereof Mar 13 - 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oakwood Cem.

18. (a) Signature of funeral director Robert S. Skuman
(b) Address macon mo
19. (a) 4/7/47 (b) Ruth Mcneely
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County macon
(c) City or town macon 3
(If outside city or town limits, write "RURAL")
(d) Street No. _____ 2
(If rural, give location) _____ 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 13
year 1947 hour 10 minute 2 M.
21. I hereby certify that I attended the deceased from Mar 6, 1947 to Mar 13, 1947
that I last saw him alive on Mar 8, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Due to Arteriosclerosis - Hypertension
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings: _____
Of operations _____
Of autopsy _____

Duration 78 hrs
Scot
PHYSICIAN
Underline the cause to which death should be charged statistically.

27. 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 Howard N. H. H. (M. D. or other) _____
Address macon Mo Date signed 9/18/47

145

RECEIVED
District Health Officer No. 10
File Number 447-733
Date Filed APR 15 1947

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 Albert Skinner

Licensed Embalmer No. 75-1

P. O. Address Macon 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.