

FILED NOV 25 1947

Registration District No. 274

Primary Registration District No. 4547

Registrar's No. 70

1. PLACE OF DEATH:

(a) County Worth
(b) City or town Grant City
(If outside city or town limits, write "RURAL" and name of township)
(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 33 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Edith Moser Wyman

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Roy Wyman 6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased March 20, 1890
(Month) (Day) (Year)

8. AGE: Years 57 Months 7 Days 19 If less than one day hr. _____ min. _____

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

10. Usual occupation housewife

11. Industry or business _____

12. Name ----- Moser

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

14. Maiden name Marie (unknown)

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

16. (a) Informant Roy Wyman
(b) Address Grant City, Mo.

17. (a) Burial (b) Date thereof 11-12-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grant City, Mo.

18. (a) Signature of funeral director Arch E. Dingle
(b) Address Grant City, Mo.

19. (a) Nov 13 1947 (b) Reta E. Dawson
(Date received local registrar) (Registrar's signature) 2113

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Worth 113

(c) City or town Grant City
(If outside city or town limits, write "RURAL") 9

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 9
year 1947 hour 3:47 minute 30 A.M.

21. I hereby certify that I attended the deceased from August
1947, to 11/19/47, 1947;
that I last saw her alive on 11/8, 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death, Metastatic Carcinoma of Breast

Due to _____

Due to _____

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

Major findings: Of operations 50

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 0

23. Signature Frank B. Matteson (M.D. or other) md
Address Grant City, Mo. Date signed 11/19/47

Duration

2-3 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

DISTRICT HEALTH OFFICE
Cameron, Mo.

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.....

Arch C. Dangle

Licensed Embalmer No.....

3252

P. O. Address.....

Grant City, 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.