

FILED FEB 4 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2270

State File No.

WRITE PLAINLY--USING UNFAADING BLACK INK--MAKE A PERMANENT RECORD

BIRTH NO. _____		REG. DIST. NO. <u>294</u>		PRIMARY REG. DIST. NO. <u>3056</u>		Registrar's No. <u>23</u>			
1. PLACE OF DEATH a. COUNTY <u>Randolph</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Randolph</u>					
b. CITY (If outside corporate limits, write RURAL, and give township) <u>Moberly</u>		c. LENGTH OF STAY (in this place) <u>11 years</u>		c. CITY (If outside corporate limits, write RURAL, and give township) <u>Moberly</u>		OR TOWN <u>88</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>613 West Coates</u>				d. STREET ADDRESS (If rural, give location) <u>613 West Coates</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>LORETTA</u> b. (Middle) <u>WYLIE</u> c. (Last) <u>MEARS</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>January-27-1949</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Feb-27-1875</u>			
9. AGE (In years last birthday) <u>73</u>		10. MONTHS <u>11</u>		11. DAYS <u>0</u>		12. HOURS <u>0</u> MIN. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant (Retail) Ladies Ready Wear</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Scott Co. Mo.</u>			11. BIRTHPLACE (State or foreign country) <u>USA</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13a. FATHER'S NAME <u>Beattie S. Wylie</u>		13b. MOTHER'S MAIDEN NAME <u>Jane Byrnes</u>		14. NAME OF HUSBAND OR WIFE <u>John Wayne Mears</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY # (If yes, give no. or date of service) <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Wylie Mears Moberly Mo.</u>			ADDRESS <u>Moberly Mo.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 10. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
		ANTECEDENT CAUSES DUE TO (b) <u>Hypertension</u>							
		DUE TO (c)							
		11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>351X</u>						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Jan 20</u> , 1949, to <u>Jan 27</u> , 1949; that I last saw the deceased alive on <u>Jan 27</u> , 1949, and that death occurred at <u>10:30 A. m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>[Signature]</u>				23b. ADDRESS <u>[Address]</u>			23c. DATE SIGNED <u>1/28/49</u>		
24a. BURIAL-CREMATATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Jan-29-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>—</u>		24d. LOCATION (City, town, or county) (State) <u>Cape Girardeau Mo</u>			
DATE REC'D BY LOCAL REG. <u>1-28-49</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Snow Funeral Home Moberly Mo.</u>			

RECEIVED

District Health Officer No. 1

District File Number 2-49-16

Date Filed FEB 2 - 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

R. M. Carter

Licensed Embalmer No. 4117

P. O. Address Proberly 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.