

FILED OCT 17 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34065

BIRTH NO. _____ REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 3026 Registrar's No. 308

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE MISSOURI, b. COUNTY CLAY, 27	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN INDEPENDENCE		c. CITY (If outside corporate limits, write RURAL and give township) LIBERTY 21	
c. LENGTH OF STAY (in this place) 2 weeks		d. STREET ADDRESS (If rural, give location) 16 SOUTH LEONARD 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION VAIRES SANITARIUM 0			

3. NAME OF DECEASED (Type or Print) CATHERINE WALLET WYSONG	4. DATE OF DEATH OCT. 6, 1949		
a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)

5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED 1939	8. DATE OF BIRTH MARCH-22-1871	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR	IF UNDER 24 HRS.
				Months 6	Days 19	Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (State or foreign country) PARADISE, MISSOURI	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME WILLIAM EDICOTT	13b. MOTHER'S MAIDEN NAME ELIZA STONE	14. NAME OF HUSBAND OR WIFE DR. W.L. WYSONG
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME DOROTHY ANN CATES, LIBERTY, MO	ADDRESS
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		7 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Non arteriosclerotic chronic DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		351X	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <input checked="" type="checkbox"/>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <input checked="" type="checkbox"/>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR
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22. I hereby certify that I attended the deceased from Oct 2, 1949, to Oct 6, 1949, that I last saw the deceased alive on Oct 5, 1949, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE J. G. Haskins (Degree or title) M.D.	23b. ADDRESS Independence Mo	23c. DATE SIGNED Oct 8-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE OCT. 8, 1949	24c. NAME OF CEMETERY OR CREMATORY FAIRVIEW CEMETARY, LIBERTY, MISSOURI	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. Oct. 8-1949	REGISTRAR'S SIGNATURE [Signature]	GENERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS Liberty, Mo
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

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OCT 1 2 RECD

FEB 6 1950

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 *W. P. Gardner Jr.*

Licensed Embalmer No. 3934

P. O. Address Liberty, 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.