

FILED MAY 14 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12884
1731

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
c. LENGTH OF STAY (in this place) 75 yrs		3638	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4329 Woodland AVENUE		d. STREET ADDRESS (If rural, give location) 4329 Woodland AVENUE	

3. NAME OF DECEASED (Type or Print) a. (First) Anna b. (Middle) Margaret c. (Last) Wymore			4. DATE OF DEATH (Month) (Day) (Year) 4-17-51		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Oct. 4, 1961	9. AGE (In years last birthday) 89	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) HEESSE, Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME GEORGE MUELLER		13b. MOTHER'S MAIDEN NAME GRETCHEN RAESCHLER		14. NAME OF HUSBAND OR WIFE JOHN B. WYMORE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Miss Elizabeth King 4329 Woodland	

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic pneumonia		INTERVAL BETWEEN ONSET AND DEATH 3 day 331 h 4 yrs
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Senility, general DUE TO (c) Arterio sclerosis		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cerebral hemorrhage, hemiplegia, aphasia		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min)	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 Jan 1st, 1947, to 4/17, 1951, that I last saw the deceased alive on 4/17, 1951, and that death occurred at 11:40 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Terry E. Litley M.D.	23b. ADDRESS 807 Argyle Bldg.	23c. DATE SIGNED 4/18-51
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE April 20, 1951	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) LIBERTY MISSOURI
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DATE REC'D BY LOCAL REG. 4-20-51	REGISTRAR'S SIGNATURE Seraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS O.H. Newcomer's Sons 1331 BAYN CREEK KANSAS CITY, Mo.
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

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 *Basil Honey*

Licensed Embalmer No. *4224*

P. O. Address *Cashland, 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.