

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24760**

FILED JUL 25 1956

BIRTH NO. _____ REG. DIST. NO. **311** PRIMARY REG. DIST. NO. **4456** Registrar's No. **23**

1. PLACE OF DEATH a. COUNTY St. Clair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Appleton City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
c. LENGTH OF STAY (In this place) 3 1/2 weeks		d. STREET ADDRESS (If rural, give location) 1215 E. 26th St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Ellett Memorial Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Wyatt b. (Middle) Thomas c. (Last) Harper			4. DATE OF DEATH July-14-1956 (Month) (Day) (Year)		
5. SEX M		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH Oct.-4-1884		9. AGE (In years last birthday) 71		IF UNDER 1 YEAR: Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY (Retired)		11. BIRTHPLACE (State or foreign country) Appleton City, Missouri	
				12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Thomas Harper		13b. MOTHER'S MAIDEN NAME Susie Nelson		14. NAME OF HUSBAND OR WIFE Ann Harper	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY (If yes, give war or dates of service) 492-10-0292		17. INFORMANT'S SIGNATURE OR NAME Ann Harper	
				ADDRESS 1215 E. 26th, Kansas City Mo.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) RESPIRATORY PARALYSIS		DUE TO (b) PROGRESSIVE MUSCULAR ATROPHY			4 YR.
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) _____			
II. 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		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)		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 **Nov. 1954**, to **July 14, 1956**, that I last saw the deceased alive on **July 14, 1956**, and that death occurred at **8:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE R.H. Braunschweiger MD		23b. ADDRESS Appleton City Mo.		23c. DATE SIGNED July 16, 1956	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE July-17-1956		24c. NAME OF CEMETERY OR CREMATORY Appleton City Cemetery	
		24d. LOCATION (City, town, or county) Appleton City, Mo.			

DATE REC'D BY LOCAL REG July 19, 1956		REGISTRAR'S SIGNATURE Chas Atney		25. FUNERAL DIRECTOR'S SIGNATURE Melvin L. Janssen	
				ADDRESS Appleton City	

WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD

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FULL 25 1956

JUL 31 1956

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

Melvin L. Janssens

Licensed Embalmer No. 4529

P. O. Address Appleton City

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.