

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 2 1959

59-032823

Registration District No. 157 Primary Registration District No. 5588 Registrar's No. 181

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Jasper</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jasper</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sarcox Mo</u>		Length of stay in 1b <u>Life</u>		c. CITY OR TOWN <u>Sarcox Mo</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>R 7 D</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Arthur Wyatt</u>				4. DATE OF DEATH Month Day Year <u>9-17-1959</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>wh</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9-28-78</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Jasper Co Mo</u>		11. BIRTHPLACE (City and state or country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Jim Wyatt</u>			13b. MOTHER'S MAIDEN NAME <u>Margaret Humbert</u>		14. NAME OF HUSBAND OR WIFE <u>Ella Wyatt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Ella Wyatt Sarcox Mo</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Constrictive Aortic Valve</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Prolonged Recumbency</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>		
DUE TO (c) <u>Atherosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Emphysema</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)						
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE		
21. I attended the deceased from <u>8-3-59</u> to <u>9-17-59</u> and last saw her alive on <u>9-17-59</u>				Death occurred at <u>1:30 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <u>R. Newton</u> (Degree or title)				22b. ADDRESS <u>Sarcox Mo.</u>		22c. DATE SIGNED <u>9-18-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-20-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hudson Cem</u>		23d. LOCATION (City, town, or county) <u>Carthage Mo</u>		(State)		
24. FUNERAL DIRECTOR <u>Jackson &amp; Sons Sarcox Mo</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>9-25-59</u>		26. REGISTRAR'S SIGNATURE <u>Ely Clenton</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Wm K. Jackson

Licensed Embalmer No. 3959

P. O. Address Sanape

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.