

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

'59 0 4 3 7 8 3

FILED VS DEC 21 1959

STATE FILE NUMBER

Registration District No. 101 Primary Registration District No. 5410 Registrar's No. 65

EMENDED

1. PLACE OF DEATH a. COUNTY <u>DOUGLAS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>DOUGLAS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SILOAM SPRINGS,</u>		Length of stay in 1b <u>23 yrs.</u>	c. CITY OR TOWN <u>SILOAM SPRINGS,</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>X</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>TWIN BRIDGES RTE.,</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>PETER FRANK WYAS</u>			4. DATE OF DEATH Month Day Year <u>11-12-59</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>6-29-1890</u>	9. AGE (last birthday) <u>69</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>FARMER AND BRICKLAYER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>CHICAGO, ILL</u>	12. CITIZEN OF WHAT COUNTRY <u>U S A</u>	
13a. FATHER'S NAME <u>JOHN WYAS</u>		13b. MOTHER'S MAIDEN NAME <u>X</u>		14. NAME OF HUSBAND OR WIFE <u>ANNA WYAS</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>W W I</u>		16. SOCIAL SECURITY NO. <u>YES</u>		17. INFORMANT Address <u>ANNA WYAS, SILOAM SPRINGS, 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>Coronary thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 hours</u>
DUE TO (b) <u>Arteriosclerotic heart disease</u>		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 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.	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 3/21/59 to 11/12/59 and last saw him alive on 11/11/59  
Death occurred at 8:15 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>M.L. Fowler M.D.</u>		22b. ADDRESS <u>West Plains Mo.</u>		22c. DATE SIGNED <u>11/18/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>	23b. DATE <u>11-15-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LITTLE ZION</u>	23d. LOCATION (City, town, or county) <u>TWIN BIDGES, MO</u>	

24. FUNERAL DIRECTOR <u>ROBERTSONS, WEST PLAINS, MO</u>	25. DATE RECD. BY LOCAL REG. <u>12-12-59</u>	26. REGISTRAR'S SIGNATURE <u>Vestal Bushman</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS DEC 21 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 \_\_\_\_\_  
Signature of Student Embalmer

Signed *D. D. Roberts*

Licensed Embalmer No. 3437  
P. O. Address *West Me*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.