

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-049298

STATE FILE NUMBER

Registration District No. 353 Primary Registration District No. 6205 Registrar's No. 2

FILED JAN 11 1963	
1. PLACE OF DEATH a. COUNTY <u>Texas</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Pierce Twp.</u> Length of stay in 1b <u>Yrs.</u> 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"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Texas</u> c. CITY OR TOWN <u>Willow Springs, St. Rt.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Star Route</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED First Middle Last <u>Mary Vianna WYRICK</u>	
4. DATE OF DEATH Month Day Year <u>Dec. 28, 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/28/70</u>
9. AGE (last birthday) <u>92</u>	IF UNDER 1 YEAR <u>10</u> Months <u>0</u> Days IF UNDER 24 HR <u>0</u> Hours <u>0</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY _____
11. BIRTHPLACE (City and state or country) <u>Texas County, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Henry Mitchell</u>	13b. MOTHER'S MAIDEN NAME <u>Rebeca Kilgore</u>
14. NAME OF HUSBAND OR WIFE <u>Madison M. Wyrick</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>
17. INFORMANT Address <u>Fred Wyrick, St. Rt., Willow Spgs. 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>Arteriosclerosis generalized</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
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 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>8/1/60</u> , to <u>12/28/62</u> and last saw her/him alive on <u>12/28/62</u> Death occurred at <u>11:00 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Sign as doctor or title) <u>Dr. Amos L. Coffey, M.D.</u>	22b. ADDRESS <u>Willow Springs, Mo.</u>
22c. DATE SIGNED <u>12/31/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/31/62</u>
23c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>	
23d. LOCATION (City, town, or county) (State) <u>Willow Springs, Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Burns- Willow Springs, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>1-3-63</u>
26. REGISTRAR'S SIGNATURE <u>Julia Powell</u>	

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

11070
2 1070
3 1
4 1
5 2
6
7 0
8 2
94500
10
11
1290-0
133-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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 T. R. Burns *T. R. Burns*

Licensed Embalmer No. 4214

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