

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-046897

STATE FILE NUMBER

Registration District No. 4 Primary Registration District No. 4014 Registrar's No. 118

DO NOT WRITE ON THIS STUB

FILED DEC 26 1963

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>ATCHISON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>HOLT</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>FAIRFAX</u>		Length of stay in 1b <u>1 week</u>	c. CITY OR TOWN <u>MOUND CITY</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Community Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>PRINCE LIONEL WYMAN</u>			4. DATE OF DEATH Month Day Year <u>Dec. 14, 1963</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</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>3/4/1883</u>
9. AGE (last birthday) <u>80</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RESTAURANT OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RESTAURANT</u>	11. BIRTHPLACE (City and state or country) <u>MAITLAND, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Russell Wyman</u>	
13b. MOTHER'S MAIDEN NAME <u>Amelia Duchman</u>		14. NAME OF HUSBAND OR WIFE <u>Lillian Wyman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mrs. P. L. Wyman Mound City, Mo.</u>	
17. INFORMANT <u>Mrs. P. L. Wyman Mound City, Mo.</u>		Address	
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>Cerebral Anoxia</u> <u>Cardiac Arrest</u> DUE TO (b) <u>Myocardial Infarction</u> DUE TO (c) <u>3 days</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hr. 15 min.</u> <u>4 min.</u> <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. <u>not fractured right hip</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 s.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 <u>July 1959</u> to <u>Dec 14, 1963</u> and last saw him alive on <u>Dec 14, 1963</u> Death occurred at <u>2:45 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>James Humphrey M.D.</u>		22b. ADDRESS <u>MOUND CITY, Mo.</u>	
22c. DATE SIGNED <u>12/17/63</u>		22d. (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>12-16-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>100F CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>MAITLAND - Mo.</u>
24. FUNERAL DIRECTOR <u>JAMES H. CRAWFORD, MOUND CITY, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Dec. 18, 1963</u>	26. REGISTRAR'S SIGNATURE <u>Therwin N. Schoeler</u>

USE BLACK INK OR TYPEWRITER RIBBON

400000-010

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 James H. Crawford
Licensed Embalmer No. 4796

P. O. Address Mound City, 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.