DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

REC'D NOV 13 1939

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 34044

Registration District No. 791 1003

Primary Registration District No.

Registrar's No. 8582

**1. PLACE OF DEATH:**

(a) County 2

(b) City or town Saint Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
2425 Goode Avenue
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 20 years
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County 1

(c) City or town Saint Louis 11
(If outside city or town limits, write "RURAL")

(d) Street No. 2425 Goode Avenue
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Angie Belle Wyatt

3. (b) If veteran, name war

3. (c) Social Security No. None

4. Sex Female

5. Color or race Negro

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Joseph D. Wyatt

6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased July 4, 1867
(Month) (Day) (Year)

8. AGE: Years 71 Months 2 Days 29 If less than one day br. min.

9. Birthplace Danville (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Alec Richardson
13. Birthplace Unavailable (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Fannie-Unavailable
15. Birthplace Unavailable (City, town, or county) Missouri (State or foreign country)

16. (a) Informant's own signature Joseph Wyatt
(b) Address 2425 Goode Avenue

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/1939 (Month) (Day) (Year)
(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director Charles J. Gates
(b) Address 4107 Finney Avenue

19. (a) OCT 6 1939 (Date received local registrar) (b) J. F. Bradrick (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month October day 3, year 1939 hour 1 minute A. M.

21. I hereby certify that I attended the deceased from 7, 16 ~~10, 8~~, 1939 to October 2, 1939 that I last saw her alive on October 2, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death Valvular Inefficiency

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature Wm L. Perry (M. D. or other)
Address 4452 Kennerly Avenue Date signed 10/4/39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Rev. 5-17-39 1 X19511

**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 James A. Johnson, Registered Apprentice No. _____, working under my personal supervision.

Signed James A. Johnson

Licensed Embalmer No. 3522

P. O. Address 4107 Finney Avenue

**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, above space should be left blank.**