

S. No. 2  
-11-10-39  
5-17-39  
-I X21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

17958

State File No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

608

Registration District No. 85

Primary Registration District No. 1001

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
2004 North 22nd St. 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 53 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan  
(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2004 North 22nd St.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Emma Olivia Wyatt 300  
(b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. NONE

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Hollie E. Wyatt 6. (c) Age of husband or wife if alive 55 years  
7. Birth date of deceased April 23, 1881  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
59 1 8 hr. \_\_\_\_\_ min.

9. Birthplace Deadwood So. Dakota  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business own home

MOTHER FATHER { 12. Name Joseph Y. Anderson  
13. Birthplace Unknown Ohio  
(City, town, or county) (State or foreign country)  
14. Maiden name Mollie Transeau  
15. Birthplace Plattsburg Missouri  
(City, town, or county) (State or foreign country)

18. (a) Informant Hollie E. Wyatt  
(b) Address 2004 North 22nd St.

17. (a) Burial (b) Date thereof June 3, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem.  
Clark Mortuary

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address 5025 King Hill Ave.

19. (a) June 3 1940 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 31  
year 1940 hour 5 minute 15 a. M.

21. I hereby certify that I attended the deceased from May 31 - 1940  
\_\_\_\_\_ 19\_\_\_\_ to May 31 1940  
that I last saw her alive on \_\_\_\_\_ 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis

Due to Myocarditis

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

85 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) 300  
Address 408 Cochrane Blvd Date signed June 3 1940

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

*Dr. Wend  
Cochy 13149.*

**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, on ~~May~~ May 31, 194

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Earl A. Clark*

Licensed Embalmer No. 3476

P.O. Address..... St. Joseph, 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 this body is not embalmed, above space should be left blank.**