

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

**JAN 23 1941**

**44082**

**1. PLACE OF DEATH**

County Stoddard Registration District No. \_\_\_\_\_  
 Township Duck Creek Primary Registration District No. 619  
 City Peoria 2 (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Willis Wyeth  
 (a) Residence, No. Peoria mo St. \_\_\_\_\_ Ward. \_\_\_\_\_  
 (Usual place of abode)  
 Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

**3. SEX** Male **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED, OR DIVORCED** single

**21. DATE OF DEATH (MONTH, DAY, AND YEAR)** Dec. 31, 1940

**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF**

**22. I HEREBY CERTIFY, That I attended deceased from** Dec. 30, 1940, to Dec. 31, 1940

**6. DATE OF BIRTH (MONTH, DAY, AND YEAR)** Nov 9 1868

I last saw him alive on Dec. 31, 1940 Death is said to have occurred on the date stated above, at 7:30 P. m.

**7. AGE** YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. of \_\_\_\_\_ min.  
72 1 22

The principal cause of death and related causes of importance were as follows:

**OCCUPATION**  
**8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.**  
**9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.** Farmer  
**10. Date deceased last worked at this occupation (month and year)**  
**11. Total time (years) spent in this occupation**

Influenza  
 Date of onset \_\_\_\_\_  
 Other contributory causes of importance: \_\_\_\_\_

**12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** Ind.

**FATHER**  
**13. NAME** Willis Wyeth

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

**14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** Not known

**MOTHER**  
**15. MAIDEN NAME** Not known

**23. If death was due to external causes (violence), fill in also the following:**  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

**16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)**

**17. INFORMANT (ADDRESS)** Chas Slaven Peoria mo

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

**18. BURIAL, CREMATION, OR REMOVAL PLACE DATE** Peoria Cem. Jan 2 1941

**24. Was disease or injury in any way related to occupation of deceased?** No

**19. UNDERTAKER (ADDRESS)** Floyd Morgan Peoria mo

If so, specify \_\_\_\_\_  
 (Signed) L. B. Bunn M. D.  
 (Address) Peoria, mo.

**20. FILED** \_\_\_\_\_ 19\_\_\_\_ Registrar \_\_\_\_\_

RECEIVED

District Health Officer No.

District File Number 141-7

Date Filed 1/8/4

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 44082

Registration District No. 840

Primary Registration District No. 6102

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

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

**1. PLACE OF DEATH:**  
 (a) County Stoddard  
 (b) City or town Duck Creek  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
 \_\_\_\_\_  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 In this community \_\_\_\_\_ (Specify whether  
 years, months or days)

**3. (a) PRINT FULL NAME** Willis Wyeth  
 (b) If veteran, name war \_\_\_\_\_  
 (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w  
 6. (a) Single, widowed, married, divorced s  
 (b) Name of husband or wife \_\_\_\_\_  
 (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased \_\_\_\_\_  
 (Month) (Day) (Year)

**8. AGE:** Years 72 Months 1 Days 22  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
 (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

**MOTHER** { 12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
 (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
 (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 1-3-1941 (b) Bernard Dupont  
 (Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
 (c) City or town \_\_\_\_\_  
 (If outside city or town limits write "RURAL")  
 (d) Street No. \_\_\_\_\_  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Month Dec day 31  
 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

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

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?  
 \_\_\_\_\_

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

23. Signature L. Burris (M. D. or other) \_\_\_\_\_  
 Address Peoples Inc Date signed \_\_\_\_\_

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

