

41688

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

JAN 13 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 218

Primary Registration District No. 3015-

Registrar's No. 157

1. PLACE OF DEATH:

(a) County COOPER
(b) City or town BOONVILLE, MO.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
ALEX VAN RAVENSWARDY HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days
(Specify whether
In this community Life
years, months or days)

3. (a) PRINT FULL NAME ELEHANE WYATT.

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife RUTH KITE WYATT 6. (c) Age of husband or wife if alive 17 years

7. Birth date of deceased. 12-20-1911
(Month) (Day) (Year)

8. AGE: Years 30 Months 6 Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Rockport, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation FARMING

11. Industry or business _____

MOTHER FATHER { 12. Name Thomas W. Wyatt
13. Birthplace Howard Co. Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Luella Sheper
15. Birthplace Howard Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature J. S. Wyle
(b) Address Rockport Mo. R.F.D.

17. (a) Burial (b) Date thereof 12/28/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Big Springs

18. (a) Signature of funeral director J. S. Wyle
(b) Address New Franklin Mo

19. (a) 12-27-41 (b) Sheper
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County BOONE
(c) City or town RURAL RR Rockport Mo
(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 26
year 1941 hour 5 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from DEC 1 22, 1941, to DEC 26, 1941;
that I last saw him alive on 12-26, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal Obstruction
Volvulus of ileum 12-21-41

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____
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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Robert W. Wells (M. D. or other) _____
Address Boonville, Mo Date signed 12-25-41

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

1-9-42

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed

N. S. Hall

Licensed Embalmer No. 3515

P. O. Address New Franklin, 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.