

No. 2
9-4-41
7-39
X2948

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

28690

State File No.

FILED SEP 9 1943

Registration District No. 3039

Primary Registration District No. 3039

Registrar's No.

1. PLACE OF DEATH:

(a) County Linn

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

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 50 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn 58

(c) City or town Marceline 2
(If outside city or town limits, write "RURAL.")

(d) Street No. N. Kansas Ave
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 0
If yes, name country.

3. (a) PRINT FULL NAME CHARLES W. WYLIE

3. (b) If veteran, name war no

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 22
year 1943 hour 4 minute 20A M.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Anna Wylie 6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased Sept 29 1869
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 2 1943 to Aug 22 1943
that I last saw him alive on Aug 22 1943
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

72 10 23 hr. min.

Immediate cause of death:

Due to Bronchopneumonia 3 da.

Due to Cerebral hemorrhage 7 da.

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

10. Usual occupation Water Department

Other conditions (Include pregnancy within 3 months of death)

11. Industry or business

12. Name Thompson Wylie

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

14. Maiden name Adriese O'Brien

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

PHYSICIAN

Major findings: 870

Of operations

Of autopsy

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs Anna Wylie

(b) Address Marceline Mo

17. (a) Burial (b) Date thereof Aug 23 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation mt Olivet

18. (a) Signature of funeral director James M. Laughlin

(b) Address Marceline Mo

19. (a) (b) (Registrar's signature)

(Date received local registrar)

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 2

23. Signature John W. Olson (M. D. or other) DO.

Address Marceline Mo Date signed 9-25-43

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

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.....

Dale Bunch

Licensed Embalmer No.....

4088

P. O. Address.....

Marilyn M

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, fact should be so stated above.

Registration District No. 385

Primary Registration District No. 3039

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Linn

(b) City or town Marceline
(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 _____ (Specify whether _____)

In this community _____
years, months or days)

3. (a) PRINT FULL NAME Charles W. Wylie

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Sept 29 1869
(Month) (Day) (Year)

8. AGE: Years 72 Months 10 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) 7/1/43 (b) P. J. Patrick
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____

that I last saw him alive on _____, 19____ and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to Cerebral hemorrhage

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) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTAL

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

28690