

FILED JUN 10 1946 STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 586

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(c) Name of hospital or institution State Hosp # 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 mo 22 da
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Charles
(c) City or town Camden
(If outside city or town limits, write "RURAL")
(d) Street No. 2
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

3. (c) PRINT FULL NAME Glarence E. Wyckoff

3. (b) If veteran, name war WW 3. (c) Social Security No. 200

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 3

6. (b) Name of husband or wife not given 6. (c) Age of husband or wife if alive years

7. Birth date of deceased not given
(Month) (Day) (Year)

8. AGE: Years 86 * Months Days If less than one day hr. min.

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

10. Usual occupation laborer

MOTHER FATHER
11. Industry or business
12. Name not given
13. Birthplace 4 5 9
(City, town, or county) (State or foreign country)
14. Maiden name " " "
15. Birthplace " " 4
(City, town, or county) (State or foreign country)

16. (a) Informant Chester Wyckoff

(b) Address St. Joseph

17. (a) B. Magnolia (b) Date thereof 5-20-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation State Hosp # 2

18. (a) Signature of funeral director Flawerty Funeral Home

(b) Address St. Joseph

19. (a) May 21, 1946 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 20 year 1946 hour 7:20 minute 1 M.

21. I hereby certify that I attended the deceased from 5/19 1946 to 5/20 1946; that I last saw him alive on 5/19 1946; and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis
Brightfield pneumonia
Due to Empyema
Due to months

Duration
1 da
months

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations
Of autopsy 101

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 L. S. Shuck (M. D. or other) MD
Address State Hosp. St. Joseph Date signed 5/20/46

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

14743

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.....

Licensed Embalmer No.....

P. O. Address.....

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.