S. No. 2
DM—5-43
v. 5-17-39
o I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 5 1947

Registration District No. 317

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 3444

Primary Registration District No. 3070

Registrar's No. 216

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Webster Groves, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 219 Sylvester /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 46 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96

(c) City or town Richmond Heights 0
(If outside city or town limits, write "RURAL") 0

(d) Street No. 7659 Lindbergh Drive 3
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No) /

If yes, name country

3. (a) PRINT FULL NAME Ida May Tate Wyatt

3. (b) If veteran, name war No.

3. (c) Social Security No. - -

4. Sex F. /

5. Color or race W.

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

6. (b) Name of husband or wife Grant Wyatt, dec.

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

7. Birth date of deceased April (Month) 2 (Day) 1865 (Year)

8. AGE: Years 81 Months 9 Days 28 If less than one day hr. min.

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

10. Usual occupation At. Home

11. Industry or business

FATHER
12. Name James Tate
13. Birthplace Tate Springs, Tenn. (City, town, or county) (State or foreign country) /

MOTHER
14. Maiden name Julia Ann Christian
15. Birthplace Summerset, Ky. (City, town, or county) (State or foreign country) /

16. (a) Informant Grant Wyatt, Jr.
(b) Address 219 Sylvester, Webster Groves

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 2 - 1 - 1947 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Alexander Sons
(b) Address 6175 Delmar

19. (a) 1-31-47 (Date received local registrar) (b) Ruth J. Allen M.D. (Registrar's signature) M.S.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 30
year 1947 hour 12:- minute 47 A.M.

21. I hereby certify that I attended the deceased from Jan 9, 1947, to Jan 30, 1947
that I last saw he alive on Jan 28, 1947
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Thrombosis	3 weeks.
Due to 61	
Due to	
Other conditions Diabetes mellitus (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? (Specify type of place)
While at work? (e) Means of injury //

23. Signature Lois C. Wyatt (M. D. or other) M.D.
Address 124 E. Adams Kirkwood Date signed 1-30-47

(Licensed Embalmer's Statement on Reverse Side)

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 Thomas R. Jenwick

Licensed Embalmer No. 3793

P. O. Address 6175 Delmar

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.