V. S. No. 2
50M—5-42
Rev. 5-17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 20 1947

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 36916

Registration District No. 374 Primary Registration District No. 4547 Registrar's No. 65

1. PLACE OF DEATH:

(a) County Worth

(b) City or town Grant City Missouri
(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 Entire Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Worth 11

(c) City or town Grant City Mo
(If outside city or town limits, write "RURAL")

(d) Street No. ✓
(If rural, give location)

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

If yes, name country ✓

3. (a) PRINT FULL NAME James Ezra Wyman

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex M O

5. Color or race W

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

6. (b) Name of husband or wife Blanch Wyman

6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased Dec (Month) 12 (Day) 1874 (Year)

8. AGE: Years 72 Months 9 Days 18 If less than one day ..... hr. ..... min.

9. Birthplace Excelsor Springs Mo (City, town, or county) (State or foreign country) 6

10. Usual occupation Retired Farmer & Merchant

11. Industry or business " " "

FATHER
12. Name C H Wyman
13. Birthplace Unknown (City, town, or county) (State or foreign country) ✓ 9

MOTHER
14. Maiden name Angeline Clevenger
15. Birthplace Unknown (City, town, or county) (State or foreign country) ✓ 9

16. (a) Informant Blanch Wyman
(b) Address Grant City Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2 - 47 (Month) (Day) (Year)
(c) Place: burial or cremation Grant City Missouri

18. (a) Signature of funeral director John Andrews
(b) Address Grant City Mo

19. (a) Oct 11-1947 (Date received local registrar) (b) Keta E. Dawson (Registrar's signature) 24

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 29 year 1947 hour 1 minute 30A M.

21. I hereby certify that I attended the deceased from July 1947 to 29 Sept 1947; that I last saw him alive on 29 Sept 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	10 dy
Due to Arteriosclerotic Cardiovascular Disease	10 yrs
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Frank B. Matheson (M. D. or other)
Address Grant City Date signed 12 Oct 47

(Licensed Embalmer's Statement on Reverse Side)

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 John Andrews, Registered Apprentice No._____, working under my personal supervision.

Signed John Andrews

Licensed Embalmer No. 4211

P. O. Address Grant City 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, fact should be so stated above.