

FILED JUL 25 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Dr. Siceluff  
23157  
State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 138 PRIMARY REG. DIST. NO. 2000 Registrar's No. 633

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) <u>626 Hovey</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. John Hosp.</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Marvin</u> b. (Middle) <u>W.</u> c. (Last) <u>Wyett</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 16, 1949</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	
8. DATE OF BIRTH <u>March 3, 1889</u>		9. AGE (In years last birthday) <u>69</u>		10. UNDER 1 YEAR Months _____ Days _____	
10. UNDER 2 YRS. Hours _____ Min. _____		11. BIRTHPLACE (State or foreign country) <u>Brookfield, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Optometrist</u>			

13a. FATHER'S NAME <u>Charles Wyett</u>		13b. MOTHER'S MAIDEN NAME <u>Carter</u>		14. NAME OF HUSBAND OR WIFE <u>Edith Jane Wyett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If res. give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Edith Jane Wyett Springfield Mo.</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs.</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u>		?	
		DUE TO (c) _____		331A	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>congestive heart failure</u>		6 mo.	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Springfield Greene Mo</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Dec 13, 1948 to July 16, 1949, that I last saw the deceased alive on July 16, 1949, and that death occurred at 11:05 PM from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>		23b. ADDRESS <u>609 Cherry St.</u>		23c. DATE SIGNED <u>July 19 49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		24b. DATE <u>7/20/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Newcomer Crematory</u>	
		24d. LOCATION (City, town, or county) <u>Kansas City, Mo.</u>			

DATE REC'D BY LOCAL REG. <u>7-19-49</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>H.H. Lohmeyer Springfield, Mo.</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEC 27 1958

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

*Walter E. Hamilton*

Signed \_\_\_\_\_

Student Embalmer

Licensed Embalmer No. 3808

P. O. Address Springfield, 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.