

No. 300
10-28

FILED DEC 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41847
64
Registrar's No.

BIRTH NO. REG. DIST. NO. 238 PRIMARY REG. DIST. NO. 4355

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY New Madrid | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Arkansas | |
| b. CITY OR TOWN New Madrid | | b. COUNTY Ouachita | |
| c. LENGTH OF STAY (in this place) | | c. CITY OR TOWN Stephens | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION No. 1 | | d. STREET ADDRESS (If rural, give location) General Delivery | |

| | | | | | | | | | | | | |
|--|--|-----------------------------|-----------------------|---|--|----------------------------|--|---|--|--|--|-----------------------------------|
| 3. NAME OF DECEASED (Type or Print) a. (First) Adolph | | | b. (Middle) Wyrick | | | c. (Last) Wyrick | | | 4. DATE OF DEATH (Month) (Day) (Year) Nov. 28 1949 | | | |
| 5. SEX M | | 6. COLOR OR RACE Colored | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | | 8. DATE OF BIRTH 7-6-26 | | | 9. AGE (In years last birthday) 23 | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad | | | | 11. BIRTHPLACE (State or foreign country) Stephens, Arkansas | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |

| | | | | | | | | |
|----------------------------------|--|--|---|--|--|-----------------------------|--|--|
| 13a. FATHER'S NAME Joe Wyrick | | | 13b. MOTHER'S MAIDEN NAME Essie Todd | | | 14. NAME OF HUSBAND OR WIFE | | |
|----------------------------------|--|--|---|--|--|-----------------------------|--|--|

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|--|--|--|--|---|--|---------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. W. V. W. No. 2 430-42-3810 | | 17. INFORMANT'S SIGNATURE OR NAME Joe Wyrick | | ADDRESS | |
|--|--|--|--|---|--|---------|--|

| | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| 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, asphyxia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Truck and Motor car hit on Rail Road Crossing on Highway 61. Fractured skull, broken legs and arms. 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | INTERVAL BETWEEN ONSET AND DEATH 30 1/2 27 | |
|---|--|--|--|--|--|--|--|--|--|

| | | | | | | | |
|------------------------|--|----------------------------------|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
|------------------------|--|----------------------------------|--|--|--|--|--|

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|--|--|---|--|---|--|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) accident | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) New Madrid Mo. | |
| 21d. TIME OF INJURY 11-28-49 | | 21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? Hit by truck | |

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

| | | | | | | | |
|--------------------------------|--|-------------------|--|---------------------------------|--|------------------------------|--|
| 23a. SIGNATURE L. H. G. ... | | (Degree or title) | | 23b. ADDRESS New Madrid, Mo. | | 23c. DATE SIGNED 11/29/49 | |
|--------------------------------|--|-------------------|--|---------------------------------|--|------------------------------|--|

| | | | | | | | |
|---|--|----------------------|--|--|--|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE 12-6-49 | | 24c. NAME OF CEMETERY OR CREMATORY Macedonia Cemetery | | 24d. LOCATION (City, town, or county) (State) Stephens, Arkansas | |
|---|--|----------------------|--|--|--|---|--|

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|--------------------------------------|--|---|--|--|--|------------------------------|--|
| DATE REC'D BY LOCAL REG. 12-13-49 | | REGISTRAR'S SIGNATURE Helen Louise Jones | | 25. FUNERAL DIRECTOR'S SIGNATURE Hicks Funeral Home | | ADDRESS ---Hope, Arkansas | |
|--------------------------------------|--|---|--|--|--|------------------------------|--|

(Licensed Embalmer's Statement on Reverse Side)

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

JAN 18 1950
FEB 3 1950
MAR 9 1950

OCT 25 1955

RECEIVED DEC 20
District Health Office
District File Number 124
Date Filed

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

Leo H. Hylgert

Signed _____
Student Embalmer

Licensed Embalmer No.

3803

P. O. Address

New Madrid

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.