

No. 300
10.48

NOV 20 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39173

State File No. _____
Registrar's No. 215

BIRTH NO. _____ REG. DIST. NO. 157 PRIMARY REG. DIST. NO. 3028

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jasper	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Carthage St		c. LENGTH OF STAY (In this place) 77 yrs	
d. FULL NAME OF HOSPITAL OR INSTITUTION 818 Poplar St		d. STREET ADDRESS (If rural, give location) No. Locust St	
3. NAME OF DECEASED a. (First) WILLIAM b. (Middle) B. c. (Last) WYATT			4. DATE OF DEATH Nov 8, 1952
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED divorced	8. DATE OF BIRTH Dec 25, 1874
9. AGE (In years last birthday) 77		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) trucker	10b. KIND OF BUSINESS OR INDUSTRY hauling
11. BIRTHPLACE (City and State or Foreign Country) Carthage, Mo		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Frank Wyatt		13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	17. INFORMANT'S SIGNATURE OR NAME Mrs. Claud Redmond
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.		19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) LOBAR Pneumonia right side ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) stroke left side at 4 months. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. ACCIDENT SUICIDE HOMICIDE (Specify)	
21a. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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 11-9-52, 19__, to 11-8-52, 19__, that I last saw the deceased alive on 11-7-52, 19__, and that death occurred at 7:40p m., from the causes and on the date stated above.	
23a. SIGNATURE R. E. Baker		23b. ADDRESS Carthage, Mo	
23c. DATE SIGNED 11-10-52		24. BIRTHAL, CREMATION, REMOVAL (Specify) burial	
24b. DATE Nov 11, 1952		24c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
24d. LOCATION (City, town, or county) (State) Carthage, Mo		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Knell Mortuary, Carthage, Mo	
25a. DATE REC'D BY LOCAL REG. 11-10-52		25b. REGISTRAR'S SIGNATURE 139	

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

493

3493

490 X

RECEIVED 11-18-52

Jasper County Health Office

County File Number 52-11-883

Date Filed 11-18-52

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.

Student
Student Embalmer

Signed Frederick H. Knell

Licensed Embalmer No. 4440

P. O. Address Carthage, 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.