FILED SEP 3 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30582
STATE FILE NUMBER

Registration District No. 381 Primary Registration District No. 6179 Registrar's No. 93

1. PLACE OF DEATH
a. COUNTY: Sullivan
b. CITY OR TOWN: Pollock — Inside Limits: Yes ☑ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): — Length of stay in Hospital:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: Sullivan
c. CITY OR TOWN: Pollock — Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location): 105 E — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Ezza Middle: Marion Last: Wyant

4. DATE OF DEATH: Month 8 Day 22 Year 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☑ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 5-25-1889

9. AGE (In years last birthday): 68 — IF UNDER 1 YEAR: Months / Days 2 — IF UNDER 24 HRS.: Hours 27 / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Carpenter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): Pollock, Mo

12. CITIZEN OF WHAT COUNTRY?: U S

13. FATHER'S NAME: James M. Wyant

14. MOTHER'S MAIDEN NAME: Isabel McCormick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 489-32-4043

17. INFORMANT Address: Anna Wyant - Pollock - Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 48 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Generalized arteriosclerosis — years
DUE TO (c): Chronic hypertension — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE CONDITION GIVEN IN PART I(a): 331X

19. WAS AUTOPSY (PERFORMED)? YES ☐ NO ☑

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from May 31-55 to Aug 22-57 and last saw ~~he~~ him alive on Aug 22-57
Death occurred at 5:45 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Chas L. Judd — (Degree or title): DO — **22b. ADDRESS**: Kirksville Mo — **22c. DATE SIGNED**: 8/23/57

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **23b. DATE**: 8-25-57 — **23c. NAME OF CEMETERY OR CREMATORY**: Campbell Cem. — **23d. LOCATION** (City, town, or county): Sullivan Co — (State): Mo

24. FUNERAL DIRECTOR: Schoene's — **ADDRESS**: Milan Mo

25. DATE RECD. BY LOCAL REG.: 8-28-57

26. REGISTRAR'S SIGNATURE: Mrs. M. W. Burkett

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was er

by me, or by .....; Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Dwight Schoene

Licensed Embalmer No. 26.

P. O. Address Milan

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.