

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032745

FILED VS OCT 13 1959

Registration District No. 146 Primary Registration District No. 4237 Registrar's No. 433

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Jackson</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Raytown</u> Length of stay in 1b <u>30 min</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>11900 E 61st. St.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> c. CITY OR TOWN <u>Blue Springs</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>3 mi South East</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Raymond</u> Middle <u>William</u> Last <u>Wyatt</u>				<b>4. DATE OF DEATH</b> Month <u>Oct</u> Day <u>6</u> Year <u>1959</u>									
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>11/3/1899</u>		<b>9. AGE</b> (last birthday) <u>59</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Construction</u>				<b>11. BIRTHPLACE</b> (City and state or country) <u>Blue Springs, Mo.</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>			
<b>13a. FATHER'S NAME</b> <u>William Wyatt</u>				<b>13b. MOTHER'S MAIDEN NAME</b> <u>Lillie Gore</u>				<b>14. NAME OF HUSBAND OR WIFE</b> <u>Maurine</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>496-09-4449</u>		<b>17. INFORMANT</b> <u>Maurine Wyatt</u> Address <u>Blue Springs Mo.</u>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Atherosclerotic Heart Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)									
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____				<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		COUNTY _____ STATE _____	
<b>21. I attended the deceased from _____ to _____ and last saw her/him alive on _____.</b> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.													
<b>22. SIGNATURE</b> (Degree or title) <u>Dr. W. S. Kelly, M.D., M.P.H., County Health Officer</u>						<b>22b. ADDRESS</b> <u>6627 Parkview Court</u>				<b>22c. DATE SIGNED</b> <u>10-9-59</u>			
<b>23a. BURIAL CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE</b> <u>10-9-59</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Blue Springs Cem</u>				<b>23d. LOCATION</b> (City, town, or county) (State) <u>Blue Springs Mo</u>					
<b>24. FUNERAL DIRECTOR</b> <u>Webb Funeral Home</u> ADDRESS <u>Blue Springs Mo</u>				<b>25. DATE RECD. BY LOCAL REG.</b> <u>10-9-59</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>James S. Kelly</u>							

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

890-211-51

**STATEMENT BY LICENSED EMBALMER**

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

~~or by~~ \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed William Frees

Licensed Embalmer No. 4733

P. O. Address Blue Springs

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

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