

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

572

**1. PLACE OF DEATH**

County Clay Registration District No. 198  
Township Fishing river Primary Registration District No. 3011  
City Excelsior Springs (No. ...., St. .... Ward)

File No. ....  
Registered No. 4

**2. FULL NAME**

Jacob R Wyman  
(a) Residence. No. 715 Isley St. .... Ward. ....  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred 25 yrs. .... mos. .... ds. How long in U. S., if of foreign birth? yrs. .... mos. .... ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sarah Wyman

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 26 - 1933

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
97 1 19

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work. Retired farmer  
(b) General nature of industry, business, or establishment in which employed (or employer).  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ky

**PARENTS**  
10. NAME OF FATHER Christian Wyman  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) ky  
12. MAIDEN NAME OF MOTHER Martha Roane  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) ky

14. INFORMANT E. E. Cantow  
(Address) Excelsior Springs, Mo.

15. FILED 1/16, 19 31 W. D. Craven REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-15 1931

17. I HEREBY CERTIFY, That I attended deceased from Jan 3, 1931, to Jan 15, 1931, that I first saw him alive on Jan 13, 1931, and that death occurred, on the date stated above, at 9 a. .... m.

18. THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
110 Old Age  
162 Influenza of pneumonia  
acute dyspnea

CONTRIBUTORY (SECONDARY) (duration) .... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) C. P. Bentley, M. D.  
, 19 (Address) Excelsior Springs Mo

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Resgah Jan 16 1931

20. UNDERTAKER ADDRESS Excelsior Springs Mo  
Herbert Hope

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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