

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.

UNITED STATES BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

20275

1. PLACE OF DEATH

County De Kalb
Township De Kalb
City De Kalb

Registration District No. 665
Primary Registration District No. 5894

File No. _____
Registered No. 161
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. Route # 3 m. W. St. # 65 Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Widow Anna B. Wise

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 23-1844

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or min.
85 6 2

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Farmer
(b) General nature of industry, business, or establishment in which employed (or employer). Self
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) W. Virginia

10. NAME OF FATHER Isaac. Wise

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) West Virginia

12. MAIDEN NAME OF MOTHER Betty E. McElroy

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Dont know

14. INFORMANT W. B. Wise
(Address) Sealia Route #2

15. FILED 639, 80 J. L. Love REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 25 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to June 24, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at 6:50 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

45 460 Concussion of Brain
(duration) 2 yrs. 2 mos. ✓ ds.
CONTRIBUTORY (SECONDARY) Dont know
(duration) ✓ yrs. ✓ mos. ✓ ds.

18. WHERE WAS DISEASE CONTRACTED

1 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? yes DATE OF Oct 1 1919

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? no

(Signed) Th. J. Colburn, M. D.
, 19____ (Address) Sealia, W. Va.

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Sealia W. Va.

DATE OF BURIAL 6/27 1930

20. UNDERTAKER McKunham Bros ADDRESS Sealia

