

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.

JUN 1 1940

Registration District No. 750

Primary Registration District No. 5985

State File No. _____

Registrar's No. 1679

1. PLACE OF DEATH: Ripley
 (a) County Ripley
 (b) City or town Douglas Twp.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: at home Rural
 (If not in hospital or institution, write street number or location) 2
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community 30 years
 years, months or days 252

3. (a) PRINT FULL NAME Magdeline Wisniewski
 3. (b) If veteran, name war ✓
 3. (c) Social Security No. ✓

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed
 6. (b) Name of husband or wife John Wisniewski 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased April 24-1870
 (Month) (Day) (Year)

8. AGE: Years 70 Months - Days 24 If less than one day _____ hr. _____ min.

9. Birthplace Posen Poland
 (City, town, or county) (State or foreign country)

10. Usual occupation housewife 7

11. Industry or business at home 7

MOTHER FATHER { 12. Name Szymanski 7

13. Birthplace Poland
 (City, town, or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace Poland
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Stanley Wisniewski

(b) Address Douglas Mo. R-2

17. (a) Burial (b) Date thereof 5-20-40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Polanski Mo. Cem.

18. (a) Signature of funeral director H. Jordan

(b) Address Douglas

19. (a) May 19-1940 (b) C. B. Johnson
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Ripley
 (c) City or town Douglas Twp.
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month May day 18
 year 1940 hour 10; minute 10 A. M.

21. I hereby certify that I attended the deceased from May 10, 1940 to May 18, 1940
 that I last saw him alive on May 10, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Labar Pneumonia Duration _____

Due to _____

Due to _____

Other conditions 10
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 674

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature C. Johnson (M. D. or other) _____

Address Douglas Mo Date signed _____

PHYSICIAN

 Underline the cause to which death should be charged statistically.

STATEMENT BY LICENSED EMBALMER

not embalmed

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

....., Registered Apprentice No.....
working under my personal supervision.

Signed *J. E. Jordan*

Licensed Embalmer No. *3250*

P. O. Address *Alvin, Tenn*

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, above space should be left blank.