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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **36243**
Registrar's No. **1497**

FILLED NOV 23 1941

Registration District No. **196**

Primary Registration District No. **3038**

1. PLACE OF DEATH:

(a) County **Saline**

(b) City or town **Marshall**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
none
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **most life**
(Specify whether in this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Saline** **97**

(c) City or town **Marshall** **1**
(If outside city or town limits, write "RURAL")

(d) Street No. **452 West Arrow** **2**
(If rural, give location)

(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Andrew Wise**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **none**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **2nd**
year **1941** hour **12;** minute **30** A.M.

4. Sex **male 0**

5. Color or race **white**

6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Rosie Whittman Wise**

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Dec. 11 1875**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **263** 1941 to **Oct 2** 1941;
that I last saw him **live on** **Oct 1** 1941;
and that death occurred on the date and hour stated above.

8. AGE: Years **65** Months **10** Days **9**
If less than one day _____ hr. _____ min.

Immediate cause of death _____
Arteriosclerotic Heart Disease

9. Birthplace **Indiana**
(City, town, or county) (State or foreign country)

Due to **Rt Paraplegia**

10. Usual occupation **Barber**

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

11. Industry or business _____

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER { 12. Name **John Wise**

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

14. Maiden name **Anna Solomon**

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

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **none**

(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? _____

16. (a) Informant **Delores Wise**

(b) Address **452 West Arrow, Marshall, Mo.**

17. (a) **Burial** (b) Date thereof **Oct 4 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Ridge Park**

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature **Robert Keener** (M. D. or other) **D**
Address **Marshall Mo** Date signed **10-4-41**

18. (a) Signature of funeral director **Don Short**

(b) Address **Marshall, Mo**

19. **10-4-41** (b) **Mary Kent**
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 11-10-47

STATEMENT BY LICENSED EMBALMER

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

Donald W. Short

....., Registered Apprentice No.....

working under my personal supervision.

Signed Donald W. Short - *Donald W. Short*

Licensed Embalmer No... 3757.....

P. O. Address Marshall Mo......

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, fact should be so stated above.