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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JAN 11 1946

State File No. 39958

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11436

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Deaconess Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 17

(c) City or town St. Louis 11
(If outside city or town limits, write "RURAL")

(d) Street No. 6249 Waterman Ave. 15
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Philip C. Wise

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife Catherine Wise

6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased unknown (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
about	63	--	--	hr. min.

9. Birthplace Memphis (City, town, or county) Tenn. 1 (State or foreign country)

10. Usual occupation Attorney

11. Industry or business

FATHER
12. Name Dr. Julius Wise
13. Birthplace (City, town, or county) Germany 4 (State or foreign country)

MOTHER
14. Maiden name Pauline Skrainka
15. Birthplace (City, town, or county) Germany 4 (State or foreign country)

16. (a) Informant Mrs. Catherine Wise
(b) Address 6249 Waterman Ave.

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof 12-28-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla Crematory

18. (a) Signature of funeral director H. Rindskopf
(b) Address 5216 Delmar Blvd.

19. (a) DEC 27 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 27 year 1945 hour 2 minute 45 A M.

21. I hereby certify that I attended the deceased from Dec 21, 1945, to Dec 27, 1945 that I last saw him alive on December 26, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral hemorrhage (apoplexy)	5 Da
Due to: Hypertension	?
Due to	
Other conditions: Arterio sclerosis (Include pregnancy within 3 months of death)	

Major findings:
Of operations 83 a1
Of autopsy

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

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

23. Signature Robt C McElvain (M. D. or other) MD
Address 4356 Warne av Date signed 12/27/45

(Licensed Embalmer's Statement on Reverse Side)

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.....

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

working under my personal supervision.

Signed.....

Licensed Embalmer No. 4029

P. O. Address.....

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.