

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2833

State File No. _____

FILED JAN 21 1946

Registration District No. 4-270-131

Primary Registration District No. 1-35-4210

Registrar's No. 11

1. PLACE OF DEATH:
(a) County Harrison
(b) City or town Ridgeway 7720
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: S. E. part town
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community 5 1/2 yrs. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Jahn Grant Wise
3. (b) If veteran, name war _____
3. (c) Social Security No. 1

4. Sex MS 5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Yda Belle Wise
6. (c) Age of husband or wife if alive 61 years
7. Birth date of deceased 4-4-1884
(Month) (Day) (Year)

8. AGE: Years 60 Months 7 Days 19
If less than one day hr. _____ min. _____

9. Birthplace Garden Grove Neb
(City, town or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business _____

12. Name William Wise

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

14. Maiden name Martha Woodman

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

16. (a) Informant Yda Belle Wise

(b) Address Ridgeway Mo.

17. (a) Burial (b) Date thereof 11-25-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rockland Cemetery

18. (a) Signature of funeral director Robert H. Bopp

(b) Address Ridgeway 7720

19. (a) 11/25/45 (b) L. K. Dremer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Harrison
(c) City or town Ridgeway
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 23
year 1945 hour 4 minute 45 AM.

21. I hereby certify that I attended the deceased from June 25, 1945 to Nov. 23, 1945.
that I last saw him alive on Nov. 22, 1945,
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Tuberculosis Duration yrs

Due to Tubercle Bacillus infection

Due to _____

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

Major findings:
Of operations _____
Of autopsy ✓ 130

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? _____

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

23. Signature J. B. Taylor (M. Dr or other) MD

Address Ridgeway Mo. Date signed 11-24-45

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

100173

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 Robert R Bagges

Licensed Embalmer No. 33-76

P. O. Address Redgway 920.

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.