

S. No. 2
M-12.45
v. 5-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 29 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17465

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2237

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

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Grosse Nursing Home
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 4 months
(Specify whether years, months or days)
 In this community 10 years

3. (a) PRINT FULL NAME Joseph Wesley Isle
 3. (b) If veteran, name war no
 3. (c) Social Security No. 490-16-3565

4. Sex male 5. Color or race white
 6. (a) Single, widowed, married, divorced widowed
 6. (b) Name of husband or wife Margaret Isle
 6. (c) Age of husband or wife if alive years
 7. Birth date of deceased March 4, 1861
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>86</u>	<u>2</u>	<u>15</u>	hr. min.

9. Birthplace Chariton Co., Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation retired
 11. Industry or business Son's Artificial Limb Co.

MOTHER FATHER {
 12. Name Peter Isle
 13. Birthplace England
(City, town, or county) (State or foreign country)
 14. Maiden name Lucy Smith
 15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. W. E. Isle
 (b) Address 1519 West 85th. Terr.
 17. (a) removal (Burial, cremation, or removal) (b) Date thereof 5-21-47
(Month) (Day) (Year)
 (c) Place: burial or cremation Mt. Hope, K. C. Kans.

18. (a) Signature of funeral director D. W. Newcomer's Sons
 (b) Address 1401 Brush Creek Blvd.
 19. (a) 5-21-47 (Date received local registrar) Heraldine Holmes (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City "Rural"
(If outside city or town limits, write "RURAL")
 (d) Street No. 1519 W. 85th. St. Terrace
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month May day 19
 year 1947 hour 4 minute 50 P. M.
 21. I hereby certify that I attended the deceased from Feb. 3, 1944 to May 19, 1947,
 that I last saw him alive on May 11, 1947,
 and that death occurred on the date and hour stated above.

Immediate cause of death arteriosclerotic heart disease
 Duration 3 yrs.
 Due to arteriosclerosis

Due to _____
 Other conditions senility- prostatic hypertrophy
(include pregnancy within 3 months of death)
wore catheter 2 yrs.

Major findings: none
 Of operations _____
 Of autopsy none
in nursing home for 3 yrs.
 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) (Type of business or industry) (Season of injury)
 23. Signature Carl R. Ferris M. D. of Mo.
 Address 934 Argyle Bldg. Date signed May 24, 1947

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.....

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.

10. Usual occupation RETIRED
(City, town, or county) (State or foreign country)

11. Industry or business SOYS ARTIFICIAL LITER BO

MOTHER FATHER } 12. Name PETER ISLE

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

14. Maiden name LUCY UNKNOWN SMITH

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

16. (a) Informant Mr. W. E. Isle

(b) Address 1519 West 85th Terr.

17. (a) burial (b) Date thereof 5-21-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Hope, R.C. Co.

18. (a) Signature of funeral director D. N. Newcomer's Sons

(b) Address 1401 BRUSH CREEK BLYD

19. (a) 5-21-47 (b) G. M. Holmes
(Date received local registrar) (Registrar's signature)

Other conditions Smelly - Prostatic hypertrophy -
(Include pregnancy within 3 months of death)

was castrated 2 yrs

Major findings: none

Of operations 95

Of autopsy none

In nursing home for 3 yrs!

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? no (Specify type of place)
 Means of injury _____

23. Signature Paul R. Ferris (M. D. or other) MD

Address 934 Argyle Bldg. Date signed 5-20-47

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

W. B. Noflinger

Licensed Embalmer No.....

3938

P. O. Address.....

Lawrence City, 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.