

No. 2  
8-43  
5-17-39  
337823

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

FILED JUL 21 1947

State File No. **23527**

Registration District No. **74**

Primary Registration District No. **4061**

Registrar's No. **45**

**1. PLACE OF DEATH:**

(a) County **Galdwell**

(b) City or town **Brayner**

(c) Name of hospital or institution: **/**

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **11 Months** (Specify whether years, months or days)

In this community **11 Months**

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **-** (b) County **13**

(c) City or town **0**

(If outside city or town limits, write "RURAL")

(d) Street No. **0**

(If rural, give location) **0**

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

If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** **Ella J. Wise**

3. (b) If veteran, name war **--**

3. (c) Social Security No. **356 22 8925**

4. Sex **female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **widow**

6. (b) Name of husband or wife **Theo. Wise** 6. (c) Age of husband or wife if alive **--** years

✓ Birth date of deceased **April 22, 1874** (Month) (Day) (Year)

**8. AGE:**

|           |          |           |                      |
|-----------|----------|-----------|----------------------|
| Years     | Months   | Days      | If less than one day |
| <b>73</b> | <b>2</b> | <b>14</b> | hr. min.             |

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

**10. Usual occupation** **Housewife**

**11. Industry or business** \_\_\_\_\_

**12. Name** **Dorothy McGamel**

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

**14. Maiden name** **Mary Goffinet**

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

**16. (a) Informant** **Mrs. George Welker**

(b) Address **Brayner, Missouri**

**17. (a) Removal** (b) Date thereof **7-2-47** (Month) (Day) (Year)

(c) Place: burial or cremation **Hall Cem. Blue Mound Ill**

**18. (a) Signature of funeral director** **Permanet Mack**

(b) Address **Brayner, Missouri**

**19. (a) 7-9-47** (b) **Mrs. Nell B Jones** (Registrar's signature) (Date recorded local registrar)

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month **July** day **6** year **1947** hour **5:30** minute **22nd** M.

**21. I hereby certify that I attended the deceased from** **April 1947** to **July 6 1947**

that I last saw him alive on **July 6 1947** and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac Decompensation**

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions **Chronic Hepatitis** (Include pregnancy within 3 months of death)

Major findings: Of operations **None**

Of autopsy **None**

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

(a) Accident, suicide, or homicide (specify) **None**

(b) Date of occurrence **None**

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

(d) Did injury occur in **None** about home, on farm, in industrial place, in public place?

(e) While at work? (Specify type of place) (c) Means of injury **None**

**23. Signature** **Cardinal J. D. Decker** (M. D. or other)

Address **Brayner, Missouri** Date signed **July 4 1947**

**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 *Bernard Neal*

Licensed Embalmer No. *2801*

P. O. Address *Prayner, 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 23527  
Registrar's No. 45-

Registration District No. 74 Primary Registration District No. 4061

1. PLACE OF DEATH:

(a) County Caldwell

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

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

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether years, months or days)

In this community \_\_\_\_\_ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Ella J. Wise

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased April 22  
(Month) (Day) (Year)

8. AGE: Years 73 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country) Ohio

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 7-9-47 (b) Mrs. Nell B Jones  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Mo

(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATE FROM

20. DATE OF DEATH: Month \_\_\_\_\_ year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (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? \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY 6

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

