

FILED JAN 12 1949

STANDARD CERTIFICATE OF DEATH

State File No. 41208

BIRTH NO. _____ REG. DIST. NO. 311 PRIMARY REG. DIST. NO. 4456 Registrar's No. _____

43
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY St. Clair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Clair	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Appleton City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Osceola (Rural) Osceola Twp	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) Appleton City Mo.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Ellet Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Ida	b. (Middle)	c. (Last) WISNER	4. DATE OF DEATH (Month) (Day) (Year) 12/25/48
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 2/15/1871	9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeping	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Clair County Mo. 99	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Daniel H. Disney	13b. MOTHER'S MAIDEN NAME Nancy Pebely	14. NAME OF HUSBAND OR WIFE Edward Wisner
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME Josie Wisner Osceola Mo.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthemia, etc. It means the disease, injury, or complication which caused death. 935	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 yr
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 31 July, 1948, to 25 Dec, 1948, that I last saw the deceased alive on 25 Dec, 1948, and that death occurred at 10:20 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W. E. ...	23b. ADDRESS Appleton City, Mo 25 Dec 48	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 12/27/48	24c. NAME OF CEMETERY OR CREMATORY Osceola Cemetery	24d. LOCATION (City, town) or county (State) Osceola Missouri
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DATE REC'D BY LOCAL REG. Jan. 5 1949	REGISTRAR'S SIGNATURE Mrs. Cleo Abney	25. FUNERAL DIRECTOR'S SIGNATURE H. B. ...	ADDRESS Osceola Mo
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RECEIVED

District Health Officer No. 7, .

District File Number LA 48-1585

Date Filed 1-11-49

SEP 11 1958

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.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed J B Goodrich

Licensed Embalmer No. 3038

P. O. Address Oscoda 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.