

FILED JUN 16 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21884

State File No. 4994
Registrar's No. 1003

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE _____ b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (In this place) <u>0</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		17			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G Phillips Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>27-2013^a Can</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Henry</u>		b. (Middle) _____		c. (Last) <u>Wise Jr</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 4 1949</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>Dec 4 1896</u>			
9. AGE (In years last birthday) <u>52</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>barber</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Canton Miss</u>			
12. CITIZEN OF WHAT COUNTRY? _____		13a. FATHER'S NAME <u>Henry Wise</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Doyle</u>		14. NAME OF HUSBAND OR WIFE <u>Deanie Wise</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Matthie Williams</u>		ADDRESS <u>2037^a Cole</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic Heart Disease</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Undetermined</u> DUE TO (c) _____ 2. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u> <u>Arteriosclerotic Gangrene both legs</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Undet.</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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) <u>930</u>					
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? <u>4200</u>					
22. I hereby certify that I attended the deceased from <u>4-27</u> , 19 <u>49</u> , to <u>6-4</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>6-4</u> , 19 <u>49</u> , and that death occurred at <u>2:20 p. m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Clara L Daniels M. D.</u>				23b. ADDRESS <u>2601 N Whittier St</u>		23c. DATE SIGNED <u>6-6-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		24b. DATE <u>June 10 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Canton Miss</u>		24d. LOCATION (City, town, or county) (State) <u>Canton Miss</u>			
DATE REC'D BY LOCAL REG. <u>JUN 8 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Fusater</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>F. C. Shear 42-14 Delmas</u>					

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

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

Guylton H. Swain

Licensed Embalmer No. 45 80

P. O. Address 4214 Delmar

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.