

FILED NOV 15 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33690**
Registrar's No. **452**

4220

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

BIRTH NO. _____		REG. DIST. NO. 137		PRIMARY REG. DIST. NO. 4218		REGISTRAR'S NO. 452	
1. PLACE OF DEATH a. COUNTY Henry				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE Missouri b. COUNTY Henry			
b. CITY (If outside corporate limits, write RURAL and give town) Windsor		c. LENGTH OF STAY (in this place) 27 years		c. CITY (If outside corporate limits, write RURAL and give township) Windsor			
d. FULL NAME OF HOSPITAL OR INSTITUTION 203 East Jackson				d. STREET ADDRESS (If rural, give location) 203 East Jackson			
3. NAME OF DECEASED (Type or Print) a. (First) William			b. (Middle) Henry		c. (Last) Wiseman		4. DATE OF DEATH (Month) (Day) (Year) Nov. 3, 1949
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH April 13 1880		9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months 6 Days 20
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail carrier-Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Morgan County, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME William Riley Wiseman			13b. MOTHER'S MAIDEN NAME Sarah Kidwell		14. NAME OF HUSBAND OR WIFE Margaret Wiseman		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Margaret Wiseman, Windsor, Mo.			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Decompensation ANTECEDENT CAUSES DUE TO (b) chronic myocarditis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH 3 mos ? 4222
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)			
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?			
22. I hereby certify that I attended the deceased from 6-21 , 19 49 , to 11-3 , 19 49 , that I last saw the deceased alive on 11-3 , 19 49 , and that death occurred at 10 AM. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Ray B Jordan M.D.				23b. ADDRESS Windsor Mo		23c. DATE SIGNED 11-4-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 11-4-49	24c. NAME OF CEMETERY OR CREMATORY Laurel Oak		24d. LOCATION (City, town, or county) (State) Windsor, Missouri		
DATE REC'D BY LOCAL REG. Nov-11-49		REGISTRAR'S SIGNATURE Florence Adair		25. FUNERAL DIRECTOR'S SIGNATURE Huston Turner		ADDRESS Windsor Missouri	

(Licensed Embalmer's Statement on Reverse Side)

REC
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RECEIVED
District Health Officer No. 7,
District File Number 10-49-1342
Date Filed 11-14-49

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.

Signed William M. Turner

Signed _____
Student Embalmer

Licensed Embalmer No. 4648

P. O. Address Windsor

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.