

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8094

State File No.

1814

FILED MAR 11 1953

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u> <u>0396</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Frisco Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>625 So. National</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u> b. (Middle) <u>OSCAR</u> c. (Last) <u>Wise.</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>2</u> <u>15</u> <u>53</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>June 11, 1890</u>		9. AGE (In years last birthday) <u>62</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gen Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>R.R. Communications</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	
13a. FATHER'S NAME <u>J. W. Wise</u>		13b. MOTHER'S MAIDEN NAME <u>M. Shandon</u>		14. NAME OF HUSBAND OR WIFE <u>ARLEI</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Orlie Wise, Springfield, Mo.</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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Undifferentiated Malignant Lymphoma</u> 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.		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>	
--	--	---	--	---	--

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>2021</u>	

22. I hereby certify that I attended the deceased from Oct. 13, 1952, to Feb. 15, 1952, that I last saw the deceased alive on Feb. 14, 1952, and that death occurred at 5:00 p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Frank J. Amann MD</u>		23b. ADDRESS <u>4460 Laclede</u>		23c. DATE SIGNED <u>2-16-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>2-16-53</u>		24c. NAME OF CEMETERY OR CREMATORY	
DATE REC'D BY LOCAL REG. <u>FEB 16 1953</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe, 4700 Washington Blvd.</u>	

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

MAY 17 1954

MAR 21 1954

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 *John A. Denehey* _____

Licensed Embalmer No. *4194* _____

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.