

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

State File No. **22932**

FILED JUL 27 1955

BIRTH NO. _____ REG. DIST. NO. 217 PRIMARY REG. DIST. NO. 3045 Registrar's No. 56

1. PLACE OF DEATH a. COUNTY <u>Mississippi</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Mississippi</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN: <u>Charleston, Mo.</u>		c. CITY OR TOWN <u>Charleston</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home</u>		e. STREET ADDRESS (If rural, give location) <u>403 N. Hoggie, St.</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>William</u>	b. (Middle) <u>Henry</u>	c. (Last) <u>Isom</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>June 10 1955</u>
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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>Nov. 13, 1871</u>	9. AGE (In years last birthday) <u>83</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Brakeman</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Dogwood Community</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Charles Isom</u>	13b. MOTHER'S MAIDEN NAME <u>Francis Fodge</u>	14. NAME OF HUSBAND OR WIFE <u>Lillian William Isom</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) _____	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Lillian W. Isom</u>	ADDRESS <u>Charleston, Mo.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>acute pulmonary edema</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive cardiac</u> <u>vascular disease</u> DUE TO (c) <u>and chronic pyelonephritis</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>		<u>443X</u>	

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 Jan 18, 1954, to June 10, 1955, that I last saw the deceased alive on June 9, 1955, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>William L. Davis M.D.</u>	23b. ADDRESS <u>Charleston Mo.</u>	23c. DATE SIGNED <u>6-11-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>6/12/1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>City</u>	24d. LOCATION (City, town, or county) (State) <u>Sikeston, Scott, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>7-9-55</u>	REGISTRAR'S SIGNATURE <u>Jean G. Jones</u>	55. FUNERAL DIRECTOR'S SIGNATURE <u>W. E. ...</u>	ADDRESS <u>Charleston, Mo.</u>
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(Licensed Embalmer, Statement on Reverse Side)

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

No. 300
10. 48

JUL 22 REC'D

RECEIVED

Miss. Co. Health Dept

County File No. _____

Date Filed ~~JUL 25 1955~~

JUL 22 1955

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.....
Signature of Student Embalmer

Signed *J. E. McMillan*.....
Licensed Embalmer No. *4629*

P. O. Address *E. Prairie*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.