

FILED SEP 11 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27230
STATE FILE NUMBER
3705
REGISTRAR'S NO.

Registration District No. 149 Primary Registration District No. 1002

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|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>Kansas City 3318</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3010 East 27th Street</u> Length of stay in 1b <u>30 YEARS</u> | | d. STREET ADDRESS (If outside, give location) <u>3010 East 27th Street</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|--|-------------------------------|--|--|---|---|--|--|
| 3. NAME OF DECEASED (Type or print) <u>EFFIE BELL WISEMAN</u> First Middle Last | | | 4. DATE OF DEATH <u>AUGUST-19-1956</u> Month Day Year | | | | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>FEB. 28-1873</u> | | 9. AGE (In years last birthday) <u>83</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>NOBLESVILLE INDIANA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>WILBUR WHETSALL</u> | | | | 14. MOTHER'S MAIDEN NAME <u>ANN MEYERS</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>Miss Nellie Wiseman K.C. Mo.</u> Address <u>3010 E. 27th St.</u> | | | |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cholera miasmatica</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u> <u>5 yrs</u> <u>5 yrs</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) <u>Anterior Aneurysm</u> | |
| | | DUE TO (c) <u>Chol. miasmatica</u> 592X | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NO</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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|--|--|--|--|
| 20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m. <u>NO</u> | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | |
| | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |

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|---|--|
| 21. I attended the deceased from <u>Aug 1, 1956</u> to <u>Aug 19, 1956</u> at <u>2150 P.</u> I last saw her alive on <u>Aug 19, 1956</u> at <u>2150 P.</u> on the date stated above; and to the best of my knowledge, from the causes stated. | |
| 22a. SIGNATURE (Degree or title) <u>M. B. Casebolt M.D.</u> 22b. ADDRESS <u>4000 Baltimore St. E. Mo.</u> 22c. DATE SIGNED <u>8/20/56</u> | |

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|---|--|---|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE <u>AUG 23 1956</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK CEM.</u> | | 23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u> | |
| 24. FUNERAL DIRECTOR <u>D.W. Newcomer's Home</u> ADDRESS <u>7321 Brook Creek K.C. Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>8-23-56</u> | | 26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u> | | | |

(Licensed Embalmer's Statement on Reverse Side)

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
M. B. Casebolt

MEDICAL CERTIFICATION

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 *Edward M. Smith*
44
Licensed Embalmer No.....

P. O. Address *K.S. 10*

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.