

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9-000489

STATE FILE NUMBER

FILED JAN 20 1959

Registration District No. 49 Primary Registration District No. 5174 Registrar's No. 2

300
1-57

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY CAMDEN		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY CAMDEN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Climax Springs		c. CITY OR TOWN Climax Springs	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ←		d. STREET ADDRESS (If outside, give location) years	
3. NAME OF DECEASED (Type or print) First Middle Last Losy WISEMAN		4. DATE OF DEATH Month Day Year JAN 10 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 18, 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Gullivan Co Mo
13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME SARAH E James	14. NAME OF HUSBAND OR WIFE William H. Wiseman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No No		16. SOCIAL SECURITY NO. No	17. INFORMANT Address William L. Wiseman Climax Springs Mo
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHIAL PNEUMONIA Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) SENILITY DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 491X			INTERVAL BETWEEN ONSET AND DEATH THREE WEEKS
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK 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	
21. I attended the deceased from 1940 to JAN 10, 1959 and last saw her alive on JAN 6, 1959 Death occurred at 8:15 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) J.E. Brayge Don 2		22b. ADDRESS Wheatland, Mo	
22c. DATE SIGNED 1-14-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jan 13, 1959	23c. NAME OF CEMETERY OR CREMATORY Climax Springs Cemetery	23d. LOCATION (City, town, or county) (State) Climax Springs Benton Co, Mo
24. FUNERAL DIRECTOR ADDRESS John J Reser Warsaw		25. DATE RECD. BY LOCAL REG. Jan 15-1959	26. REGISTRAR'S SIGNATURE Alda Eldred

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 *John F. Reser*

Licensed Embalmer No. *4098*

P. O. Address *Warsaw*

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.