

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010143

STATE FILE NUMBER

FILED APR 2 1959

Registration District No. 700

Primary Registration District No.

Registrar's No. 55

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| 1. PLACE OF DEATH a. COUNTY <u>MACON</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>MACON</u> | |
| b. CITY OR TOWN <u>Callao</u> | | c. CITY OR TOWN <u>Callao</u> <u>610</u> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION | | d. STREET ADDRESS (If outside, give location) | |
| Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| Length of stay in lb | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |

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|------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|-----------------------------------------------------------------------|-------------------------------------------|---------------------------------------------|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Nettie Preston Wisdom</u> | | | 4. DATE OF DEATH Month Day Year <u>3. 24 - 59</u> | | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-16-1903</u> | 9. AGE (In years last birthday) <u>53</u> | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>College mound Mo</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13a. FATHER'S NAME <u>Wm Wisdom</u> | | 13b. MOTHER'S MAIDEN NAME <u>Mary Howell</u> | | 14. NAME OF HUSBAND OR WIFE <u>Lyle B. Wisdom</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. | | 17. INFORMANT <u>Lyle B. Wisdom</u> Address <u>Callao</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>Coronary Thrombosis</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Coronary Arteriosclerosis</u> | | |
| | DUE TO (c) <u>4201</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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| 20a. ACCIDENT <input 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. | | |

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| 20d. INJURY OCCURRED WHILE AT WORK <input 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 <u>Callao</u> | COUNTY <u>Mo</u> | STATE <u>Mo</u> |
| 21. I attended the deceased from <u>4-21-56</u> to <u>3-24-59</u> and last saw ^{her} _{him} alive on <u>3-22-59</u> Death occurred at <u>10:30</u> <u>A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | |

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|------------------------------------------------------------------|-----------------------------|-----------------------------------------------------------|--------------------------------------------------------|------------------------------------|
| 22a. SIGNATURE <u>Frank H. Coffin, D.D.</u> (Degree or title) | | 22b. ADDRESS <u>106 1/2 Vine, Macon</u> | | 22c. DATE SIGNED <u>3-28-59</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>3-28-59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>CONCORD Cem.</u> | 23d. LOCATION (City, town, or county) <u>Callao</u> | (State) <u>Mo</u> |

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| 24. FUNERAL DIRECTOR <u>Rev. J. J. ...</u> | ADDRESS <u>Bevier</u> | 25. DATE RECD. BY LOCAL REG. <u>3/30/59</u> | 26. REGISTRAR'S SIGNATURE <u>Clute M. Neely</u> |
|-----------------------------------------------|--------------------------|------------------------------------------------|----------------------------------------------------|

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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. S. Edwards*

Licensed Embalmer No. *1961*
P. O. Address *Perkins*

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.

6