

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011534

STATE FILE NUMBER

2464

FILED MAR 30 1959

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST JOHN 4071</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>DR PAUL HOSPITAL</u>		Length of stay in 1b <u>3 MO.</u>	d. STREET ADDRESS (If outside, give location) <u>3616 EMINENCE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <u>MILTON EDWIN WISOR</u> First Middle Last			4. DATE OF DEATH Month Day Year <u>3-9-59</u>		
5. SEX <u>MALE</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>7-12-1898</u>	9. AGE (In years for birthday) <u>60</u>	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REAL ESTATE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>SELF</u>	11. BIRTHPLACE (City and state or country) <u>HANCOCK WISCONSIN</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	--	--	---

13. FATHER'S NAME <u>JERED WISOR</u>	14. MOTHER'S MAIDEN NAME <u>FRANCES J FRENCH</u>
---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>498-14-5843</u>	17. INFORMANT <u>NEBBIE WISOR</u> Address <u>3616 EMINENCE ST JOHN MO</u>
---	---	--

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>Multiple myeloma involving both tibiae and bones of the skeleton - Cause unknown</u> DUE TO (b) <u>Cause unknown</u> DUE TO (c) <u>Universal malignant lymphatic disease</u> CONDITIONS, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 year +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a) <u>Myopathous calcinosis of spine 12. 1946</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

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.) <u>203X</u>
20c. TIME OF INJURY Hour a. m. p. m. <u>2:03 p. m.</u>	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>near 21st March 1959</u>
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20f. CITY, TOWN, OR LOCATION <u>ST LOUIS</u>

21. I attended the deceased from <u>near 21st March 1959</u> to <u>March 1959</u> and last saw her alive on <u>3/9/59</u> Death occurred at <u>St Louis 4:38 p. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>Robert Lane M.D.</u> (Degree or title)	22b. ADDRESS <u>1117 N Grand St St. Louis</u>
22c. DATE SIGNED <u>March 1959</u>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>3-12-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LAKE CHARLES</u>	23d. LOCATION (City, town, or county) (State) <u>ST LOUIS CO. MO</u>
--	-----------------------------	---	---

24. FUNERAL DIRECTOR <u>EARL HILLOMAN</u> ADDRESS <u>9709 LACKLAND</u>	25. DATE RECD. BY LOCAL REG. <u>MAR 11 '59</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>
---	---	--

(Licensed Embalmer's Statement on Reverse Side)

M. 8. 13.

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

Health, Welfare, Public Service

300 1-56 35

4071 0

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 *[Handwritten Signature]*.....

Licensed Embalmer No.....
3501

P. O. Address.....
Euclid 14

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.