

**DURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-035572**

FILED VS OCT 26 1959

Registration District No. 75 Primary Registration District No. 3015 Registrar's No. 83

STATE FILE NUMBER

UNRECORDED

1. PLACE OF DEATH a. COUNTY <u>Clinton</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Caldwell</u>											
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CAMERON</u>		Length of stay in lb <u>2 Hrs.</u>		c. CITY OR TOWN <u>Kidder</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>312 E. 3rd St.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>NONE</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <u>Otis</u> Middle <u>Wise</u> Last <u>Wise</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>16.</u> Year <u>1959</u>											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>CAUC</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>Dec. 29, 1878</u>		9. AGE (last birthday) <u>80</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SAME</u>				11. BIRTHPLACE (City and state or country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY <u>USA.</u>					
13a. FATHER'S NAME <u>John Wise</u>				13b. MOTHER'S MAIDEN NAME <u>MARY HINES</u>				14. NAME OF HUSBAND OR WIFE <u>Mattie Wise</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. <u>499-18-4029</u>				17. INFORMANT <u>Mattie Wise, Kidder, Mo.</u>				Address			
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>Cerebral Hemorrhage</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 minutes</u>					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerosis that began 10 yrs</u>															
DUE TO (c) <u>Generalized arteriosclerosis 10 yrs</u>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)										PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input 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.)											
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year													
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		COUNTY		STATE					
21. I attended the deceased from <u>12-19-58</u> to <u>10-16-59</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>9-21-59</u> Death occurred at <u>1:50 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE <u>St Wetherston MD</u> (Degree or title)						22b. ADDRESS <u>Cameron Mo</u>			22c. DATE SIGNED <u>10-16-59</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>10-16-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Winston</u>			23d. LOCATION (City, town, or county) (State) <u>Winston, Mo.</u>								
24. FUNERAL DIRECTOR <u>Stroup Funeral Home, Winston</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>Oct 19-59</u>		26. REGISTRAR'S SIGNATURE <u>Francis D Crawford</u>									

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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

*Virgil W. Stumpf*

Licensed Embalmer No.

4074

P. O. Address

*Wenatchee*

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.