

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-029724

STATE FILE NUMBER

Registration District No. 333 Primary Registration District No. 4484 Registrar's No. 156

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUL 30 1962	
1. PLACE OF DEATH a. COUNTY <u>Scott</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Commerce</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>at home</u>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Scott</u> c. CITY OR TOWN <u>Commerce</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELSIE ALLEN WISE</u>	
4. DATE OF DEATH Month Day Year <u>July 12, 1962</u>	
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>July 30, 1881</u> 9. AGE (last Birthday) <u>80</u> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HR: Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (City and state or country) <u>Commerce, Mo</u> 12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>John Sanders</u> 13b. MOTHER'S MAIDEN NAME <u>Mollie Miller</u> 14. NAME OF HUSBAND OR WIFE <u>Walter Wise (Deid)</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>None</u> 17. INFORMANT Address <u>Mrs. Grace Clark Cape Girardeau, 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>Arteriosclerotic cardio-vascular disease.</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cavity, rt. lung - Negative sputum and negative washing for acid fast organisms.</u>	
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury and part 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>1-20-60</u> to <u>7-12-62</u> and last saw her <u>alive</u> on <u>6-30-62</u> Death occurred at <u>7-12-62</u> <u>10:15 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Charles F. Wilcox, M.D.</u>	22b. ADDRESS <u>Cape Girardeau, Mo.</u> 22c. DATE SIGNED <u>7/19/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7/14/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Crestdale Cem.</u> 23d. LOCATION (City, town, or county) (State) <u>Commerce Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>BISPLINGHOFF FUNERAL HOME</u> <u>Illmo. Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>July 24-1962</u> 26. REGISTRAR'S SIGNATURE <u>Jeanette Waldman</u>

VS 300 Rev. 4/59 1000 2000 3 4 1 5 2 6 7 0 8 2 9422.1 10 11 1290-0 13 2-0	DATE AMENDED												
	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	SHOULD READ	ITEM NO.						
	AMENDED												

USE BLACK INK OR TYPEWRITER RIBBON

VS 06430052

Ms
Permit
received

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 Oliver Carmichael

Licensed Embalmer No. 4470

P. O. Address Steno. Mo

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.