

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

9433  
Do not use this space.

REC'D APR 17 1939

**1. PLACE OF DEATH**

(a) County Jackson <sup>3</sup> Registration District No. 395  
 (b) Township Kaw Primary Registration District No. 1002  
 (c) City Kansas City, Mo. <sup>1</sup> (d) Street No. 2843 Troost St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME**

<sup>207</sup> William A. Wise  
 (a) Residence, No. 3503 E 28th St. St.   
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widower  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Jennie Wise  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 4, 1848  
 7. AGE YEARS 90 MONTHS 8 DAYS 3 If LESS than 1 day, ..... hrs. or ..... min.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

FATHER 13. NAME John Wise

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER 15. MAIDEN NAME Rebecca Jones

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Mrs. Nellie Conley, 3503 E 28th St. K.C. Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt Moriah DATE Mar. 10 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) C.H. Blackman & Son, Inc. 235 Indep. Blvd. K.C. Mo.

20. FILED Mar 7 1939 M. M. Brown Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 7, 19 39

22. I HEREBY CERTIFY, That I attended deceased from March 4, 1939, to March 7, 1939.  
 I last saw him alive on March 6, 1939. Death is said to have occurred on the date stated above, at 9 AM m.

The principal cause of death and related causes of importance were as follows:  
Pneumonia  
107a  
 Date of onset 3/3/39  
 Other contributory causes of importance:

Name of operation..... Date of.....  
 What test confirmed diagnosis? Phy Exam—Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide?..... Date of injury....., 19.....  
 Where did injury occur?..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? No  
 If so, specify.....  
 (Signed) John M. Cowers M. D.  
 (Address) 3322 1/2 E. 27th St.

Dr. John Powers

27th Ordinance  
in 09119

**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 .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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 this body is not embalmed, above space should be left blank.**