

1939

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

32037

Registration District No. 104

Primary Registration District No. 3008

Registrar's No. 245

1. PLACE OF DEATH:

- (a) County Callaway ²
 (b) City or town Fulton
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution
 (Specify whether

In this community
 years, months or days)

3. (a) PRINT FULL NAME Mary Eliza Wise

3. (b) If veteran, name war
 3. (c) Social Security No.

4. Sex Y 5. Color or race W
 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Robt A Wise
 6. (c) Age of husband or wife if alive years

7. Birth date of deceased Feb 28 1853
 (Month) (Day) (Year)

- | 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|----------|----------------------|
| | <u>86</u> | <u>6</u> | <u>7</u> | hr. _____ min. |

9. Birthplace Hans Rainsie Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business

- MOTHER FATHER
 { 12. Name S. B. Callier ¹
 { 18. Birthplace Virginia
 (City, town, or county) (State or foreign country)
 { 14. Maiden name Susan Nicholas
 { 15. Birthplace Virginia
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Bessie Alexander
 (b) Address Fulton, Missouri

17. (a) Burial (b) Date thereof Sept 7, 1939
 (Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation Hillcrest Cemetery

18. (a) Signature of funeral director Geo. H. Alexander
 (b) Address Fulton, Missouri

19. (a) Sept 6, 1939 (b) R. N. Crow
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Callaway
 (c) City or town Fulton
 (If outside city or town limits, write "RURAL")

- (d) Street No. 819 Court Street
 (If rural, give location)

- (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 5th.
 year 1939 hour 7-45. minute _____ P. M.

21. I hereby certify that I attended the deceased from May 22, 39
 _____, 19____, to Sept 5th, 1939;

that I last saw her alive on Sept. 5th, 1939, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac insufficiency Duration
following, hypertension, Hemi-
plegia, (28 years standing.)

Due to XXXXXXXXXXXXXXXXXXXX
Senile dementia. Blind.

Due to _____

Other conditions Colitis, Cystitis.
 (Include pregnancy within 3 months of death)

Major findings: No operation

Of autopsy No autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
 23. Signature Greene D. McCann (M.D. or other) S. B. Callier
 Address Fulton Mo. 1 Date signed 9/6/39

8022

STATE OF TEXAS
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

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 Harold J. Christy

Licensed Embalmer No. 40025

P. O. Address Houston, Tex.

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.

11-10-1918

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

32037A
Do not use this space.

1. PLACE OF DEATH
 (a) County Callaway Registration District No. 104
 (b) Township Fulton Primary Registration District No. 3008 Registered No. 245
 (c) City _____ (d) Street No. _____
 (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 Mary Eliza Wise
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
86 6 7

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 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) _____

FATHER
 13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER
 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19 _____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____ 19 _____

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-5 1939

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____.

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:
Cardiac insufficiency following hypertensive thrombosis 28 yrs standing cause of hemiplegia unknown. Senile Dementia Blind
 Other contributory causes of importance Colitis cystica 87W

Date of onset _____

No autopsy, could not prove cause of hemiplegia. Indicated Cer. Hem.

Name of operation none Date of _____
 What test confirmed diagnosis no autopsy Was there an autopsy? _____

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? _____
 If so, specify Greene, D. McCall, M. D.
 (Signed) _____ (Address) Fulton

SUPPLEMENT

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Local Registrar.

S-32037