

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

13810

FILED MAY 3 1943
Registration District No. 42

Primary Registration District No. 10011000

State File No. _____

Registrar's No. 411

1. PLACE OF DEATH:

(a) County BUCHANAN
(b) City or town ST. JOSEPH
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
State Hospital No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community 12 yrs. 9 mo. 1 da.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mercer
(c) City or town Princeton
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Frank Wise

(b) If veteran, name war no

(c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____ years

7. Birth date of deceased _____
(Month) (Day) (Year) 1899

8. AGE: Years 44 Months - Days - If less than one day _____ hr. _____ min.

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

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

16. (a) Informant Records, State Hosp. #2

(b) Address St. Joseph, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 14, 43
(Month) (Day) (Year)

(c) Place: burial or cremation State Hospital Cemetery

18. (a) Signature of funeral director Hermon W. Siderfaden

(b) Address 1802 Union St. Joseph, Mo.

19. (a) 4-14-43 (Date received local registrar) (b) Rose Skelton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 10
year 1943 hour 8:00 minute A. M.

21. I hereby certify that I attended the deceased from November 28, 1942, to April 9, 1943;
that I last saw him alive on April 9, 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death Tubercular Peritonitis Duration 7 mo.

Due to Chronic Pulmonary Tuberculosis 15 yrs.

Due to mental deficiency 15 yrs.
Other conditions mental deficiency (Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy as above 13 fl
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 W. G. Brown (M. D.)
Address State Hospital #2 Date signed 4-14-43

Mr Coy

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.....

John F. Hurley

Licensed Embalmer No. *4050*.....

P. O. Address. *St. Joseph 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 this body is not embalmed, fact should be so stated above.