

No. 2  
M-5-43  
5-17-39  
I X3667

**FILED** APR 21 1946

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 3045-

Registrar's No. 23

**1. PLACE OF DEATH:**

(a) County Mississippi

(b) City or town Charleston  
(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 Many years  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Mississippi

(c) City or town Charleston  
(If outside city or town limits, write "RURAL")

(d) Street No. 313 N. Heggie  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Vergie Kays Wise

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. **DATE OF DEATH:** Month Feb day 20  
year 1946 hour 11 minute P M.

21. I hereby certify that I attended the deceased from Feb 15 1946 to Feb 20 1946  
that I last saw her alive on Feb 20 1946  
and that death occurred on the date and hour stated above.

4. Sex F race W

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased Oct 29 1892  
(Month) (Day) (Year)

Immediate cause of death Cerebral hemorrhage

Due to Arteriosclerosis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

**8. AGE:**

Years	Months	Days	If less than one day
<u>53</u>	<u>3</u>	<u>21</u>	_____ hr. _____ min.

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy 83%

**PHYSICIAN**  
Underline the cause to which death should be charged statistically.

9. Birthplace Anna Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation House-wife

11. Industry or business \_\_\_\_\_

12. Name James Kays

13. Birthplace Knoxville Tenn.  
(City, town, or county) (State or foreign country)

14. Maiden name Not known

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant Hubert Wise

(b) Address 313 N Heggie, Charleston, Mo

17. (a) Burial (b) Date thereof 2-25-1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Oak Grove Cemetery

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? \_\_\_\_\_

18. (a) Signature of funeral director [Signature]

(b) Address Charleston, Mo

19. (a) 3-6-46 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

23. Signature [Signature] (Specify type of place) \_\_\_\_\_ (c) Means of injury 2

Address Wyatt mo Date signed 2-27-46

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

5073

196

RECEIVED

District Health Office No.

District File Number 446-446

Date Filed 4-4-46

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**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 Edward E. Munnelle

Licensed Embalmer No. 4164

P. O. Address Charleston, 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.**