

FILED MAR 10 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 5136
880
Registrar's No.

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH, Jackson

(a) County..... Jackson

(b) City or town..... Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 mo. 20 days
(Specify whether

In this community as above
years, months or days)

3. (a) PRINT FULL NAME William Wise

3. (b) If veteran, name war no.

3. (c) Social Security No. no.

4. Sex male 0
5. Color or race white

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

6. (b) Name of husband or wife. unknown
6. (c) Age of husband or wife if alive dec. years

7. Birth date of deceased March 11 1869
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

77 11 13 hr. min.

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

10. Usual occupation at home

11. Industry or business X

12. Name William Wise

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

14. Maiden name Nannie Jones

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

16. (a) Informant Sweeney-Phillips

(b) Address Warrensburg, Missouri

17. (a) removal (b) Date thereof 2-25-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Warrensburg, Mo.

18. (a) Signature of funeral director Stine & McClure

(b) Address 3235 Gilham Plaza, K. C., Mo.

19. (a) 2-25-47 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

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

(d) Street No. 558 Main
(If rural, give location)

(e) Citizen of foreign country? NO. (Yes or No)

If yes, name country X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 24
year 1947 hour 5 minute 10 A. M.

21. I hereby certify that I attended the deceased from
Jan. 4 1947 to Feb. 24 1947
that I last saw him alive on Feb. 24 1947
and that death occurred on the date and hour stated above.

Immediate cause of death
Carcinoma of prostate

Due to.....

Due to.....

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

Major findings:
Of operations.....

Of autopsy..... None

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?
D

While at work? (Specify type of place)
(e) Means of injury.....

23. Signature J. W. Hart (M. D. or other) M.D.
Address Med. Dir. Gen'l Hosp. Date signed 2-24-47

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

Mr. [unclear]

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 *J. Blair Shepard*
Licensed Embalmer No. *4179*
P. O. Address *K. C. 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.