

FILED JUL 1 1947

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

23225
Do not use this space.

1. PLACE OF DEATH,
(a) County Wright Registration District No. 311
(b) Township MANIFIELD MO Primary Registration District No. 4535 Registered No. 111
(c) City MANIFIELD MO (d) Street No. _____ 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 Joseph Wrightsman EISEY
(a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.				
3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>IRMA EISEY</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)				
7. AGE	YEARS <u>54</u>	MONTHS <u>5</u>	DAYS <u>10</u>	If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>DOCTOR</u>			
	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) <u>AURORA MO</u>				
FATHER	13. NAME <u>CURTIS EISEY</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>AURORA MO</u>			
MOTHER	15. MAIDEN NAME _____			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>KNOXDILLE TENN</u>			
17. INFORMANT (ADDRESS) <u>IRMA EISEY, MANIFIELD MO</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Floral Hills Cemetery</u> DATE <u>July 1st 1947</u>				
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>R. W. Beebe</u> <u>Intn. Iron Works</u>				
20. FILED <u>7-5-47</u> 19 _____ <u>Ruth Stout Dep</u> <u>Local Registrar</u>				

MEDICAL CERTIFICATE OF DEATH	
21. DATE OF DEATH (MONTH, DAY, AND YEAR) <u>June 27 1947</u>	
22. I HEREBY CERTIFY, That I attended deceased from <u>June 1st 1946</u> , to <u>June 26 1947</u> I last saw him alive on <u>June 26 1947</u> Death is said to have occurred on the date stated above, at <u>12 A.M.</u> The principal cause of death and related causes of importance were as follows: <u>Cerebral Hemorrhage</u> <u>Hypertension</u> Date of onset <u>6/27/47</u>	
Other contributory causes of importance: <u>SMA</u>	
Name of operation _____	Date of _____
What test confirmed diagnosis? <u>none</u>	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? <u>no</u> If so, specify _____ (Signed) <u>W. A. Zimmerman</u> M.D. (Address) <u>Manifield Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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.

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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 P. W. Barber
Licensed Embalmer No. 3862
P. O. Address City, Ill. Ill.

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.

Registration District No. 379

Primary Registration District No. 4553

1. PLACE OF DEATH:

(a) County Wright
(b) City or town manifestly
(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 _____ (Specify whether _____)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME

Joseph Wrightman Elsey

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

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

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

7. Birth date of deceased Jan 17 (Month) (Day) (Year)

8. AGE: Years 54 Months 5 Days MO (If less than one day, hr. min.)

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

10. Usual occupation

11. Industry or business

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

16. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Specify type of place)

(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____
(b) Address _____

19. (a) 7/5/47 (b) Ruth Stout - Reg. (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____
Due to _____

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

Major findings: Of operations _____
Of 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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

JOP21
A3

23225