

FILED NOV 8 1948

Registration District No. **128**

Primary Registration District No. **5467**

Registrar's No. **9.31**

1. PLACE OF DEATH:

(a) County **Greene**
 (b) City or town **Springfield Rural Rellman Sup.**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Route 11 - Springfield
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **1**
 (Specify whether
 In this community **20 yrs.**
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene**
 (c) City or town **Springfield Rt. #11**
 (If outside city or town limits, write "RURAL")
Springfield Rt. #11
 (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 **SAMUEL E. WISEMAN**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Mary Fay** 6. (c) Age of husband or wife if alive **43** years
 7. Birth date of deceased **Sept 15 - 1904**
 (Month) (Day) (Year)

8. AGE: Years **44** Months **1** Days **11** If less than one day _____ hr. _____ min.

9. Birthplace **Wiseman Arkansas**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business **Farming**

MOTHER FATHER { 12. Name **Unknown** 9
 13. Birthplace **Unknown** 9
 (City, town, or county) (State or foreign country)
 14. Maiden name **Unknown** 9
 15. Birthplace **Unknown** 9
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mary Fay Wiseman (Wife)**

(b) Address **Springfield, Mo. Rt. #11**

17. (a) **Burial** (b) Date thereof **10-29-48**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Wiseman, Arkansas**

18. (a) Signature of funeral director **W. H. Kingman & Co**

(b) Address **Springfield, Mo.**

19. (a) **10-28-48** (b) **W. E. Handley, M.D.**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **26**
 year **1948** hour **7** minute **15** A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____,

that I last saw him **live** on **dead Oct 26,** 19**48**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Partial decapitation of head** Duration _____

Due to **Gun shot wound 20 gauge shotgun**

Due to _____

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

Major findings: Of operations **16 40** 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) **Suicide** 39

(b) Date of occurrence **10/26/48**

(c) Where did injury occur? **Bedwell Green Mo.**
 (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
on farm

While at work? **No** (Specify type of place) **shot gun**
 (e) Means of injury **blast**

23. Signature **Clayde B. Abbott** (M. D. or other) _____

Address **Springfield, Mo.** Date signed **10/26/48**

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

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.....

Mal Rhodes

Licensed Embalmer No.....

4071

P. O. Address.....

Springfield

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.