

34230

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

No. 300

10-48

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>4838</u>			
1. PLACE OF DEATH a. COUNTY <p align="center">Jackson</p>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <p align="center">Missouri</p>				b. COUNTY <p align="center">Jackson</p>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <p align="center">Kansas City</p>		c. LENGTH OF STAY (in this place) <p align="center">2 yrs.</p>		c. CITY OR TOWN <p align="center">Kansas City</p>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <p align="center">Bellerive Hotel, 214 E. Armour</p>				STREET ADDRESS (If rural, give location) <p align="center">Bellerive Hotel, 214 E. Armour</p>				3509	
3. NAME OF DECEASED (Type or Print)			a. (First) <p align="center">ARTHUR</p>		b. (Middle) <p align="center">LAMAR</p>		c. (Last) <p align="center">WISNER</p>		
4. DATE OF DEATH		(Month) (Day) (Year)		<p align="center">Oct. 18, 1954</p>					
5. SEX <p align="center">Male</p>	6. COLOR OR RACE <p align="center">White</p>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <p align="center">Married</p>	8. DATE OF BIRTH <p align="center">May 27, 1900</p>	9. AGE (in years last birthday) <p align="center">54</p>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 12 HRS. Hours		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <p align="center">Orchestra Manager</p>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <p align="center">Michigan</p>		12. CITIZEN OF WHAT COUNTRY? <p align="center">USA</p>			
13a. FATHER'S NAME <p align="center">Robert P. Wisner</p>			13b. MOTHER'S MAIDEN NAME <p align="center">Belle Warden</p>			14. NAME OF HUSBAND OR WIFE <p align="center">Frances B. Wisner</p>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <p align="center">yes W.W. # 1</p>		16. SOCIAL SECURITY NO. <p align="center">329-03-2100</p>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <p align="center">Mrs. Frances Wisner, 214 E. Armour, K.C., Mo.</p>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION							
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Sub-arachnoid hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <p align="center">45 minutes</p>		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>aneurysm of basilar</u>		undetermined					
DUE TO (c)				330 X					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Nov 2</u> , 1953, to <u>Oct 18</u> , 1954, that I last saw the deceased alive on <u>Nov 2</u> , 1953, and that death occurred at <u>3:00 A. m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>W. Donald McFarland</u> (Degree or title)				23b. ADDRESS <u>315 Ashhole Road</u>		23c. DATE SIGNED <u>10-18-54</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <p align="center">Removal</p>		24b. DATE <p align="center">10-19-54</p>		24c. NAME OF CEMETERY OR CREMATORY <p align="center">Athens, Michigan</p>		24d. LOCATION (City, town, or county) (State) <p align="center">Kalamazoo, Michigan</p>			
DATE REC'D BY LOCAL REG. <p align="center">10-18-54</p>		REGISTRAR'S SIGNATURE <p align="center"><i>Neva Minshall</i></p>		25. FUNERAL DIRECTOR'S SIGNATURE <p align="center">STINE & McCLURE UND. CO.</p>		ADDRESS <p align="center">K.C.MO.</p>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNEADING BLACK INK—MAKE A PERMANENT RECORD

Dr. M. Donald McFarland
215 Plaza Medical Bldg.

LC 1533

After 11:00

Exp-5-138 (A)

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *F. S. Wallen*

Licensed Embalmer No... *274*

P. O. Address... *RCM*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.