

FILED JUL 3 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20927

State File No.

BIRTH NO. _____ REG. DIST. NO. 156 PRIMARY REG. DIST. NO. 209 Registrar's No. 283

1. PLACE OF DEATH a. COUNTY JASPER		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY JASPER	
b. CITY (If outside corporate limits, write RURAL and give township) JOPLIN		c. CITY OR TOWN JOPLIN	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1429 JACKSON		STREET ADDRESS (If rural, give location) 1429 JACKSON	

3. NAME OF DECEASED a. (First) WALTER b. (Middle) JASPER c. (Last) WISOR			4. DATE OF DEATH (Month) (Day) (Year) JUNE 25 1956		
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	
8. DATE OF BIRTH OCT. 2, 1912		9. AGE (In years last birthday) 43		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY VICKERS, INC.		11. BIRTHPLACE (City and State or Foreign Country) JOPLIN, MISSOURI	
13a. FATHER'S NAME IRA WISOR		13b. MOTHER'S MAIDEN NAME CLARA FRESBY		14. NAME OF HUSBAND OR WIFE VIOLA MAE WISOR	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UKN		17. INFORMANT'S SIGNATURE OR NAME VIOLA WISOR ADDRESS 1429 JACKSON JOPLIN	
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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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Circulatory Failure		INTERVAL BETWEEN ONSET AND DEATH 20 min.	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Bronchogenic Carcinoma		10 min.	
DUE TO (c)		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		162X	

19a. DATE OF OPERATION 11-10-55		19b. MAJOR FINDINGS OF OPERATION Squamous Cell Bronchogenic Carcinoma Left Lung		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE None		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) None	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) None		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? None	

22. I hereby certify that I attended the deceased from 10-24-, 1955, to 6-25-, 56, that I last saw the deceased alive on 6-25-, 1956, and that death occurred at 6:15P m., from the causes and on the date stated above.

23a. SIGNATURE J. E. Stephens (Degree or title) D.O.P.		23b. ADDRESS 211 W. 2074 Joplin, Mo.		23c. DATE SIGNED 6-25-56	
24a. BURIAL CREAMATION REMOVAL 6-28-56		24b. DATE 6-28-56		24c. NAME OF CEMETERY OR CREMATORY FAIRLAND CEMETERY,	
24d. LOCATION (City, town, or county) (State) FAIRLAND, OKLAHOMA.					

DATE REC'D BY LOCAL REG. 6-28-56		REGISTRAR'S SIGNATURE Noel Merriam		25. FUNERAL DIRECTOR'S SIGNATURE STEVE PARKER MORTUARY ADDRESS JOPLIN	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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County of _____
Date Filed JUL 5 1956

~~AUG 9~~ 1962

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. M. Jones
Licensed Embalmer No. 23

P. O. Address Joplin

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.