

FILED JUN 25 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21217**

BIRTH NO. _____ REG. DIST. NO. **209** PRIMARY REG. DIST. NO. **3043** Registrar's No. **203**

1. PLACE OF DEATH a. COUNTY Marion		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Marion	
b. CITY OR TOWN Hannibal	c. LENGTH OF STAY (in this place) 20Yrs	c. CITY OR TOWN Hannibal	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 411 Mark Twain Ave.		e. STREET ADDRESS (If rural, give location) 411 Mark Twain Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) Charles b. (Middle) None c. (Last) Wiseman			4. DATE OF DEATH (Month) (Day) (Year) 5 - 24 - 56		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May 8, 1871	9. AGE (In years last birthday) 85	IF UNDER 1 YEAR Months Days Hours Min. 85
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Antique Dealer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Hannibal, Mo.		12. CITIZEN OF WHAT COUNTRY? US

13a. FATHER'S NAME Wm. A. Wiseman		13b. MOTHER'S MAIDEN NAME Mildred Walden		14. NAME OF HUSBAND OR WIFE Anna Tucker (D)	
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.		17. INFORMANT'S SIGNATURE OR NAME Hannibal, Mo. ADDRESS	

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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH		
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Self-inflicted gunshot wound to side of head				
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

21a. ACCIDENT SUICIDE HOMICIDE (Specify) suicide		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 976X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **8:30A m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J.M. O'Donnell Coroner		23b. ADDRESS Hannibal Mo		23c. DATE SIGNED 5-26-56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5-26-56	24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	24d. LOCATION (City, town, or county) (State) Hannibal, Mo.		

DATE REC'D BY LOCAL REG. 6-19-56	REGISTRAR'S SIGNATURE Dr. E. M. Lucke	25. FUNERAL DIRECTOR'S SIGNATURE By W. C. Fisher		ADDRESS Hannibal, Mo.	
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(Licensed Embalmer's Statement on Reverse Side)

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

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RECEIVED JUN 21 1956
MARION CO. HEALTH DEPT.
DATE FILED JUN 21 1956

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.....

Licensed Embalmer No... 4217

P. O. Address... annibal, ...

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.