

FILED JAN 17 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 576

BIRTH NO. _____ REG. DIST. NO. 59 PRIMARY REG. DIST. NO. 4097 Registrar's No. _____

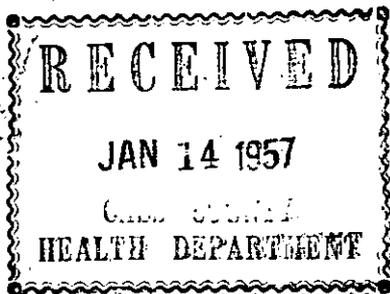
1. PLACE OF DEATH a. COUNTY CASS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY CASS	
b. CITY (If outside corporate limits, write RURAL and give township) HARRISONVILLE	c. LENGTH OF STAY (In this place) 3 mo	c. CITY (If outside corporate limits, write RURAL and give township) RAYMORE	
d. FULL NAME OF HOSPITAL OR INSTITUTION Memorial Hospital		d. STREET ADDRESS (If rural, give location) 0190	
3. NAME OF DECEASED (Type or Print) a. (First) CHARA b. (Middle) SOPHRONIA c. (Last) SMITH		4. DATE OF DEATH (Month) (Day) (Year) JAN. 1 - 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 4-1-1864
9a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) Housewife		9b. KIND OF BUSINESS OR INDUSTRY Home	9. AGE (In years last birthday) 92
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) OHIO
13a. FATHER'S NAME GEORGE ZIEGLER		13b. MOTHER'S MAIDEN NAME KATHARINE ZIEGLER	14. NAME OF HUSBAND OR WIFE Mrs Raymond Wise
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME Mrs Raymond Wise
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Enteric schistosomiasis		18. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Enteric schistosomiasis INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4500	
20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
21a. INCIDENT (Specify) suicide	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 **Oct 1956**, to **1-1-1957**, that I last saw the deceased alive on **1-1-1957**, and that death occurred at **11 A. m.**, from the causes and on the date stated above.

23a. SIGNATURE Edward S. Jones MD	(Degree or title)	23b. ADDRESS Harrisonville Mo	23c. DATE SIGNED 1-4-57
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 1-4-1957	24c. NAME OF CEMETERY OR CREMATORY FREEMAN CEMETERY	24d. LOCATION (City, town, or county) (State) FREEMAN - Missouri
DATE REC'D BY LOCAL REG. 1/3/57	REGISTRAR'S SIGNATURE Frederic Anderson	25. FUNERAL DIRECTOR'S SIGNATURE Raymond Funeral Home Springfield, Mo	

(Licensed Embalmer's Statement on Reverse Side)

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



JUN 2 1957

MAR 28 1957

JUN 7 1957

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
Student Embalmer

Signed

Gerald E. White

Licensed Embalmer No.

4956

P. O. Address

Leinsburg, Kans.

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.