

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **5348**

FILED FEB 27 1957

|   |                                  |   |   |  |   |  |   |                               |
|---|----------------------------------|---|---|--|---|--|---|-------------------------------|
| BIRTH NO. _____   |                                  | REG. DIST. NO. <u>170</u>   |   | PRIMARY REG. DIST. NO. <u>3033</u>   |   | Registrar's No. <u>29</u>  |   |                               |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Laclede</u>   |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Laclede</u> |   |  |   |                               |
| b. CITY (If outside corporate limits, write RURAL and give township)<br><u>Lebanon</u>  |                                  | c. LENGTH OF STAY (in this place)<br><u>7 1/2 days</u>  |   | c. CITY OR TOWN <u>Lebanon</u>   |   | d. Is Residence within limits of a city or incorporated town?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |                               |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Wallace Hospital</u>   |                                  |   |   | e. STREET ADDRESS (If rural, give location)<br><u>686 Millcreek Road</u>   |   |  |   |                               |
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) <u>Wilsie</u>  |                                  |   | b. (Middle) <u>Gizzard</u>                      |  | c. (Last) _____                                       |  | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br><u>Feb. 19 1957</u>       |                               |
| 5. SEX<br><u>F</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Widowed</u>  | 8. DATE OF BIRTH<br><u>April 14 1890</u>        |  | 9. AGE (In years last birthday)<br><u>66</u>          | IF UNDER 1 YEAR<br>Months _____ Days _____   | IF UNDER 24 HRS.<br>Hours _____ Min. _____                            |                               |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY _____   |   | 11. BIRTHPLACE (City and State or Foreign Country)<br><u>Humboldt Iowa</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |   |                               |
| 13a. FATHER'S NAME<br><u>William Krieriem</u>   |                                  |   | 13b. MOTHER'S MAIDEN NAME<br><u>Mary Stoebe</u> |  | 14. NAME OF HUSBAND OR WIFE<br><u>Chester Gizzard</u> |  |   |                               |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknowns) (If yes, give war or dates of service)<br><u>no</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>none</u>  |   | 17. INFORMANT'S SIGNATURE OR NAME<br><u>Edna Gizzard</u>   |   |  |   | ADDRESS<br><u>Lebanon Mo.</u> |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.                                 |                                  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial insufficiency</u><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Pulmonary Fibrosis</u><br><br>DUE TO (c) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 years</u><br><u>10 years</u> |                               |
| 19a. DATE OF OPERATION _____  |                                  | 19b. MAJOR FINDINGS OF OPERATION<br><u>525X</u>   |   |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" 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)<br><u>Lebanon Mo. 2</u>  |   |  |   |                               |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____  |                                  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21f. HOW DID INJURY OCCUR?<br>_____  |   |  |   |                               |
| 22. I hereby certify that I attended the deceased from <u>June 1948</u> , to <u>2/19/1957</u> , that I last saw the deceased alive on <u>2/19</u> , 19 <u>57</u> , and that death occurred at <u>10:30 P.M.</u> , from the causes and on the date stated above. |                                  |   |   |  |   |  |   |                               |
| 23a. SIGNATURE (Type or Print)<br><u>W. J. Froelich M.D.</u>  |                                  |   |   | 23b. ADDRESS<br><u>Lebanon Mo.</u>   |   | 23c. DATE SIGNED<br><u>2/21/57</u>   |   |                               |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 24b. DATE<br><u>2/22/57</u>   |   | 24c. NAME OF CEMETERY OR CREMATORY<br><u>Richland Cemetery</u>   |   | 24d. LOCATION (City, town, or county) (State)<br><u>Richland Mo.</u>   |   |                               |
| DATE REC'D BY LOCAL REG.<br><u>2-22-1957</u>  |                                  | REGISTRAR'S SIGNATURE<br><u>Hella L. Day</u>  |   | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>Halman Funeral Home</u>   |   | ADDRESS<br><u>Lebanon Mo.</u>  |   |                               |

(Licensed Embalmer's Statement on Reverse Side)

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

424

Received 2-25-57

Laclede County Health Unit

File No. 29

Date Filed 2-25-57

MAR 20 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.....  
Signature of Student Embalmer

Signed Dorsey M. Howe

Licensed Embalmer No. 422

P. O. Address Lebanon

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.