

pt. Health,
c. & Welfare
S. Public
alth Service

V. S. 300
ev. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 18 1957

44667

STATE FILE NUMBER
5730

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5730

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF DECEASED (If NOT in hospital, give location) Linwood		Length of stay in lb 50 yrs	d. STREET ADDRESS (If outside, give location) 3633 Woodland Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) JOSEPH A. WISE			4. DATE OF DEATH Month Dec Day 3 Year 1957		
---	--	--	--	--	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 8, 1872	9. AGE (In years last birthday) 85	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. 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 Pratt-Whitney	11. BIRTHPLACE (City and state or country) Topeka, Ks.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
---	---	--	---

13a. FATHER'S NAME James W. Wise	13b. MOTHER'S MAIDEN NAME Rachael Gouker	14. NAME OF HUSBAND OR WIFE Dora A. Wise
--	--	--

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. 499-07-9681	17. INFORMANT Address Miss Rae Wise, Brandywine Rd. Northfield Ohio
--	---	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 20 years.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		4202
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	--

20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
---	---	--	------------------------------	--------	-------

21. I attended the deceased from 7-12-57 to 9-13-57 and last saw ^{her} him alive on 9-13-57 Death occurred at 9:00 A m on the date stated above; and to the best of my knowledge, from the causes stated.	
---	--

22a. SIGNATURE James D. Dunleavy (Occupation or title) D	22b. ADDRESS 314 Westman Bldg	22c. DATE SIGNED 3 Dec 57
--	---	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12-3-57	23c. NAME OF CEMETERY OR CREMATORY Topeka Cemetery	23d. LOCATION (City, town, or county) (State) Topeka, Kansas
--	-----------------------------	--	--

24. FUNERAL DIRECTOR Mellody-McGilley-Eylar Funeral Home	ADDRESS 12-3-57	25. DATE RECD. BY LOCAL REG. 12-3-57	26. REGISTRAR'S SIGNATURE Ira Minshall
--	---------------------------	--	--

1800 E. Linwood, K. C., MO. (Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Dr. J. W. Dunleavy
3100 Throost
We 1-8143

11 am - 5 PM



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 *James E. Hackleman*

Licensed Embalmer No. *4573*

P. O. Address *KC Mo*

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.