

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-046904

STATE FILE NUMBER

FILED DEC 24 1958

Registration District No. 335 Primary Registration District No. 3074 Registrar's No. 235

300
1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Locality, manner, etc.: must appear on accompanying certificate in item 10. No symptoms will be listed. All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY <u>Scott</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Mississippi</u>		
b. CITY OR TOWN <u>Sikeston</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Charleston</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bel-Aire Nursing Home 1 Wk</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>313 N. Heggie</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert H. Wise</u>			4. DATE OF DEATH Month Day Year <u>Dec. 10, 1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28, 1881</u>	9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months Days <u>7</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Govt Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>	11. BIRTHPLACE (City and state or country) <u>Louisville, Ky</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Robert M. Wise</u>		13b. MOTHER'S MAIDEN NAME <u>Mary A. Wise</u>		14. NAME OF HUSBAND OR WIFE <u>Virgie Kays Wise</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>497-09-1442</u>	17. INFORMANT Address <u>Mrs. Paul Stallings, Charleston, Mo</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable coronary occlusion</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					<u>4301</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>RT partial hemiplegia. Gen. Arteriosclerosis.</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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 <u>12-5-58</u> to <u>12-10-58</u> and last saw <u>him</u> alive on <u>12-8-58</u> Death occurred at <u>Dec. 10, 1958 2:30 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>E. D. Urban M.D.</u>			22b. ADDRESS <u>Sikeston, Mo.</u>		22c. DATE SIGNED <u>12-16-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12/13/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>		23d. LOCATION (City, town, or county) (State) <u>Charleston, Missouri</u>
24. FUNERAL DIRECTOR <u>Mc Mickle Charleston, Mo.</u>		ADDRESS		25. DATE RECD. BY LOCAL REG. <u>12-19-50</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Ella Hunter</u>

667-800

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 *[Handwritten Signature]*

Licensed Embalmer No. *4699*
P. O. Address *Charleston*

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.