

FILED JAN 6 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 42202

BIRTH NO. 124		REG. DIST. NO. 316		PRIMARY REG. DIST. NO. 3061		Registrar's No. 460	
1. PLACE OF DEATH a. COUNTY ST. FRANCIS				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY ST. FRANCIS			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN FLAT RIVER		c. LENGTH OF STAY (In this place) 30 years		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN FLAT RIVER 94			
d. FULL NAME OF HOSPITAL OR INSTITUTION 303 CONGRESS				d. STREET ADDRESS (If rural, give location) 303. CONGRESS 52			
3. NAME OF DECEASED a. (First) GEORGE		b. (Middle) FRANKLIN		c. (Last) WISDOM		4. DATE OF DEATH (Month) (Day) (Year) December 22 1949	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		8. DATE OF BIRTH JUNE 19 1899	
9. AGE (In years last birthday) 80		10. MONTHS 6		11. BIRTHPLACE (State or foreign country) REYNOLDS COUNTY, MO		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY SELF		13a. FATHER'S NAME JACK WISDOM		13b. MOTHER'S MAIDEN NAME JANE DARR	
13c. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS HOMER WISDOM FLAT RIVER MO.	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.  I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral aneurysm ANTECEDENT CAUSES (b) arteriosclerosis Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 234X			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		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)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		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 Jan 1947, to Dec 22, 1949, that I last saw the deceased alive on Dec 21, 1949, and that death occurred at 6:30 P.M., from the causes and on the date stated above.							
23a. SIGNATURE C. H. Appherry MD (Degree or title)				23b. ADDRESS Flat River MO		23c. DATE SIGNED 10-27-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12-24-49		24c. NAME OF CEMETERY OR CREMATORY GREELEY		24d. LOCATION (City, town, or county) (State) MO	
DATE REC'D BY LOCAL REG. Dec 28, 1949		REGISTRAR'S SIGNATURE Esther Rudloff		25. FUNERAL DIRECTOR'S SIGNATURE C. Z. Bager		ADDRESS Stealy, W	

(Licensed Embalmer's Statement on Reverse Side)

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

1-3-50

Health Officer No. 4

at File Number 150-27

Date filed

### 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

B. T. Boyer

Licensed Embalmer No. 3660

P. O. Address Desloge, 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 this body is not embalmed, fact should be so stated above.