WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Wright

Township ~~Mountain Grove~~

or

Village

or

City Mountain Grove (NO. ..... St.; ..... Ward)

Registration District No. 908 File No. 51085

Primary Registration District No. 4549 Registered No. 78

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Otis Edward Wheeler

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
male	white	Single

DATE OF BIRTH Mar (Month) 30 (Day), 1900 (Year)

AGE 18 yrs. 8 mos. 5 ds. If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) —

BIRTHPLACE (City or town, State or foreign country) Texas co mo

PARENTS
NAME OF FATHER Jessie Wheeler
BIRTHPLACE OF FATHER (City or town, State or foreign country) Texas co mo
MAIDEN NAME OF MOTHER Ida E McKinney
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Texas co mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Everett Wheeler

(ADDRESS) Mountain Grove

Filed 1-14, 1919. J. M. Hubbard REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec (Month) 5 (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 3rd, 1918, to Dec 5th, 1918, that I last saw him alive on Dec 4th, 1918, and that death occurred, on the date stated above, at 10:15 a.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia following Flu.

11A

10

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. A. Ryan M.D.

1/14, 1919 (Address) Norwood

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Mountain Grove Cem

DATE OF BURIAL Dec 7, 1918

UNDERTAKER H. J. Hemwick

ADDRESS Mt Grove

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____
or
Village _____
or
City _____ (NO. _____, _____ St.; _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX | COLOR OR RACE | SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____ (Month) _____ (Day), *1* ____ (Year)

AGE _____ yrs. _____ mos. _____ ds. | If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country)

PARENTS
- NAME OF FATHER
- BIRTHPLACE OF FATHER (City or town, State or foreign country)
- MAIDEN NAME OF MOTHER
- BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191__, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day), *191* ____ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191__, to _____, 191__, that I last saw h_____ alive on _____, 191__, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191__ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL _____, 191__

UNDERTAKER | ADDRESS