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

Do not use this space.

33549

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No.
Township Kan — Primary Registration District No. 1002 — Registered No. 4309
City Kansas City (No. Kansas City General Hosp. St. Ward)

2. FULL NAME William Frank Wheeler
(a) Residence. No. 4515 Wyoming St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. 6 mos. 7 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Separated

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 17-1859

7. AGE: Years 68 — Months 2 — Days 26 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Common Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Steephentown
(STATE OR COUNTRY) New York

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) —
(STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) —
(STATE OR COUNTRY) Unknown

14. INFORMANT Record Clerk
(Address) K.C. Gen'l Hosp.

15. FILED 11/13, 1927 M. M. Crowe Asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-13- 1927

17. I HEREBY CERTIFY, That I attended deceased from 11-9-, 1927, to 11-13-, 1927 that I last saw ~~[illegible]~~ alive on 11-13 am 1927, and that death occurred, on the date stated above, at 5750 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Nephritis
131
95B
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Cardiac Decompensation
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
8 DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) George O. Lee, M. D
11/13, 1927 (Address) General Hosp. K.C. Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Mt Hope — DATE OF BURIAL: Nov 15 1927

20. UNDERTAKER: Eylau Funeral Home — ADDRESS: 1800 Linwood

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.

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