

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

Do not use this space.

✓ 36227

**1. PLACE OF DEATH**

County Carroll Registration District No. 135 File No. \_\_\_\_\_  
 Township Argue Primary Registration District No. 5201 Registered No. 118  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Martha Jane Wheeler  
 (a) Residence. No. \_\_\_\_\_ 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. mos. da. How long in U.S., if foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX ♀ 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) \_\_\_\_\_

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
68 | 10 | 14 | \_\_\_\_\_

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work House wife  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Miami Station Mo  
 (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Wm J Hill

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Adkins Mo

12. MAIDEN NAME OF MOTHER Joseph Adkins

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Carroll Mo

14. INFORMANT (Address) Joseph Wheeler  
Adkins

15. FILED 12-27, 1927 ms. E. E. 7 Wm  
 REGISTRAR Adkins

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-26 1927

17. I HEREBY CERTIFY, That I attended deceased from 12-20-27 1927, to 12-26 1927 that I last saw h. alive on 12-26-27, 1927, and that death occurred, on the date stated above, at 6 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Pneumonia Soban  
2/23/27  
108 (duration) yrs. mos. da. 6  
 CONTRIBUTORY (SECONDARY) Chronic Pulmonary TB  
 (duration) 5 yrs. mos. da. 6

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: \_\_\_\_\_

0 DID AN OPERATION PRECEDE DEATH: No DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY: No

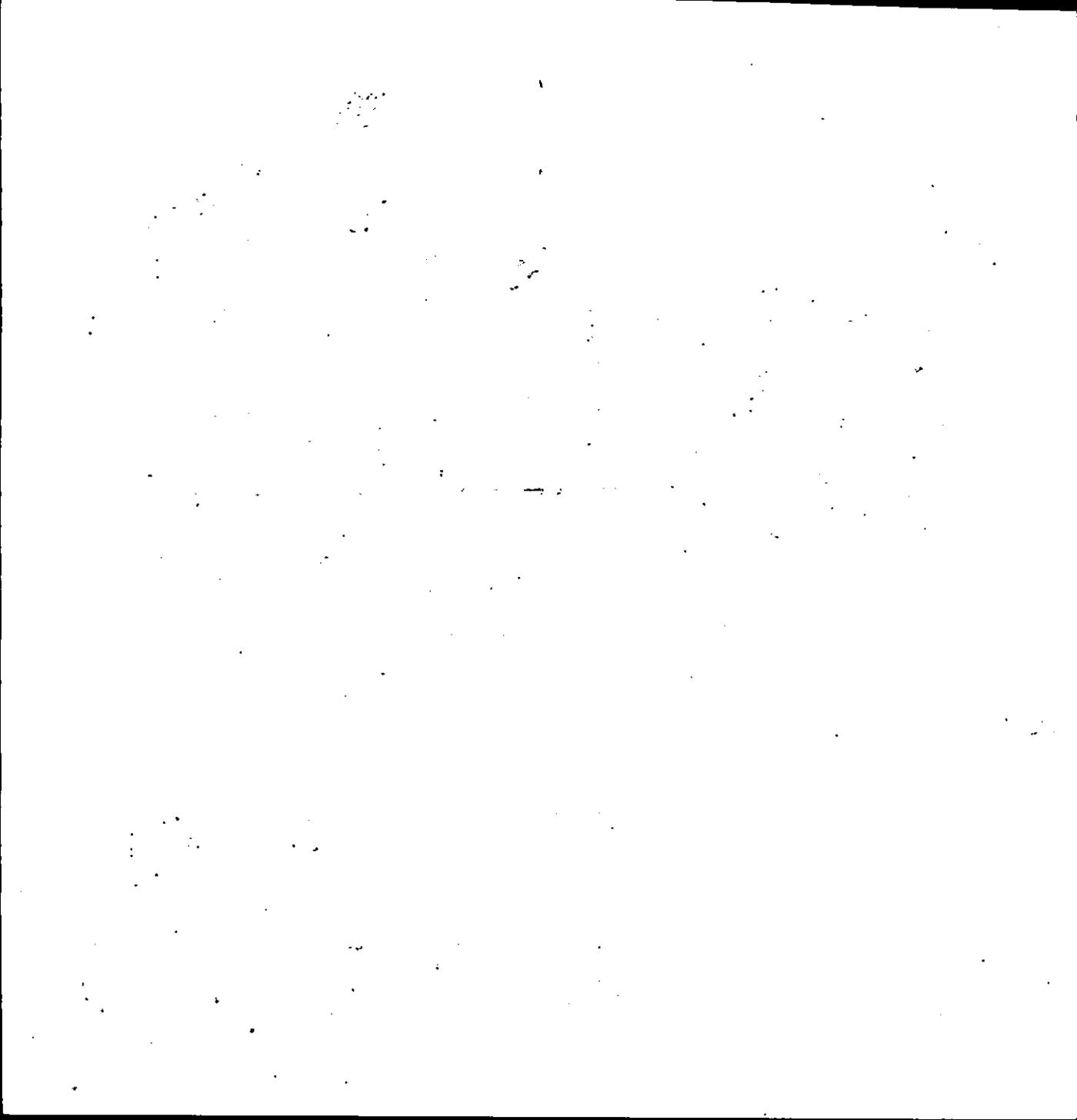
WHAT TEST CONFIRMED DIAGNOSIS: \_\_\_\_\_

(Signed) H. B. Brown, M. D.  
12-27, 1927 (Address) Carrollton 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 Adkins Cem DATE OF BURIAL 12/27 1927

20. UNDERTAKER Wheeler Bros ADDRESS Carrollton Mo



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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Carroll Registration District No. 135 File No. \_\_\_\_\_  
 Township Eyene Primary Registration District No. 201 Registered No. 118  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Martha Jane Wheeler

(a) Residence. No. \_\_\_\_\_ 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. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-12-1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
68 11 14

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work \_\_\_\_\_ (duration) yrs. mos. ds.  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

10. NAME OF FATHER \_\_\_\_\_

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

14. INFORMANT \_\_\_\_\_  
 (Address) \_\_\_\_\_

15. FILED 12-27-19-27 Mrs. E. E. Farnham  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-26-1927

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) yrs. mos. ds.  
 \_\_\_\_\_ (duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.  
 \_\_\_\_\_, 19\_\_\_\_ (Address) \_\_\_\_\_

\*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 \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-36227