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

Do not use this space. 7620

1. PLACE OF DEATH

County: Polk

Township: Jefferson

City: ..... (No. ....., ... St. ..... Ward)

Registration District No. 709

Primary Registration District No. ~~6294~~ 5938

File No. .....

Registered No. .....

2. FULL NAME Claud 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	white	Single.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug-23-1927

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	1	6	1	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) MO
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Robert Wheeler

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

12. MAIDEN NAME OF MOTHER Jessie McBride

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

14. INFORMANT Robert Wheeler
(Address) Flemington MO

15. FILED 2/25, 1929 Esther H. Saville
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 24 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb 24, 1929, to Feb 24, 1929, that I last saw him alive on Feb 24, 1929, and that death occurred, on the date stated above, at 7 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia

IDTR

..... (duration) — yrs. — mos. 4 ds.

CONTRIBUTORY .....
(SECONDARY)

..... (duration) — yrs. — mos. — ds.

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? Clinical

(Signed) A. J. Stuppelbaum, M. D.

, 19 (Address) Humansville 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 Payne Grave Yard — DATE OF BURIAL Feb 25 1929

20. UNDERTAKER R. D. Josephs — ADDRESS 3149

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 Pick
Township Jefferson
City ..... (No. ....., 6291 ..... St. ..... Ward)

Registration District No. 709
Primary Registration District No. ~~2938~~
File No. .....
Registered No. .....

2. FULL NAME Claud 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	W	S

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

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

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

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(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)

PARENTS
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 2/24, 1929 Esther H. Saville
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2 - 24 1929

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:
Pneumonia
Broncho
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (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 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

S-7620