

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

Do not use this space.

39972

PLACE OF DEATH

County Carroll

Registration District No. 138

File No. _____

Township _____

Primary Registration District No. 4078

Registered No. 30

City Norborne (No. _____) St. _____ Ward _____

2. FULL NAME Lydia M. 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 3 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 2, 1840

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
89 8 5

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

9. BIRTHPLACE (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Kentucky

10. NAME OF FATHER Leonard Mullikin

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT E.H. Musson
(Address) Norborne, Mo.

15. FILED Dec 7 19 29 E.H. Musson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) December 7 19 29

17. I HEREBY CERTIFY, That I attended deceased from Aug 16 1927, to Dec 1 1929 that I last saw him alive on Dec 1 1929 and that death occurred, on the date stated above, at 2:00 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic interstitial nephritis

131 (duration) 2 yrs. mos. ds.
87113 Cerebral hemorrhage
CONTRIBUTORY (SECONDARY)

(duration) 16 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) E.H. Musson M. D.

Dec 7 1929 (Address) Norborne, 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 Liberty Cemetery DATE OF BURIAL Dec 8 19 29

20. UNDERTAKER John Wippschies ADDRESS Hardin, Mo.

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. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

22 20 1929

26 2

30 1

Handwritten text in the top left corner, possibly a date or reference number.

Handwritten text in the bottom right corner, possibly a signature or name.