MAR 28 1930

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

Do not use this space. 7432 ~~7422~~

1. PLACE OF DEATH
County Sullivan — Registration District No. 848 — File No.
Township Penn — Primary Registration District No. 4514 — Registered No. 17
City Greencastle (No. ..... St. ..... Ward)

2. FULL NAME Samuel 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 yrs. mos. 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): Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 16 - 1867

7. AGE: Years 62 — Months 2 — Days 20 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer & Miller
(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) Illinois

PARENTS
10. NAME OF FATHER Jewell B Wheeler
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Illinois
12. MAIDEN NAME OF MOTHER Hester Parmer
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Illinois

14. INFORMANT Rufus Wheeler
(Address) Kirksville Mo

15. FILED 2/6, 1930 W Parsons REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb - 6 - 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept - 1, 1929, to Feb - 6, 1930 that I last saw him alive on Feb - 6 - 1930, and that death occurred, on the date stated above, at 6.30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Carcinoma of Liver

(duration) yrs. 9 mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Wm Parsons, M. D
2/6, 1930 (Address) Greencastle 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: Greencastle Cem — DATE OF BURIAL: 2 - 7 - 1930

20. UNDERTAKER: Glenn E Kent — ADDRESS: Green City 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. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.