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.

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

Do not use this space.

13 74

32950

File No.

Registered No. 4178

1. PLACE OF DEATH

County: Jackson

Township: Kan

City: K. C. Mo. (No. 3874 - E. 63rd St. St., Ward)

Registration District No.: 399

Primary Registration District No.: 1002

2. FULL NAME John H. Wheeler

(a) Residence. No. 3874 - E. 63rd St., 16 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	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May-11-1865

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	68	5	2	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Christian Science

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

(c) Name of employer

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

PARENTS

10. NAME OF FATHER Ira Wheeler

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) No Record

12. MAIDEN NAME OF MOTHER No record

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) No record

14. INFORMANT Genevieve T. Wheeler
(Address) 3874 East 63rd

15. FILED 10/14 1930 M. M. Brown
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-13 1930

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:

Coma

99.8

(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? No DATE OF .....

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy

10/14 1930 (Signed) Shirley Ingraham M. D.
(Address) Lightly Corner

*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
Memorial Park	10-15 1930

20. UNDERTAKER	ADDRESS
Mrs. C. L. Foster	K. C. Mo.