

DEC 20 1930

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

Do not use this space.

35532

1. PLACE OF DEATH
County Cape Girardeau Registration District No. 125
Township _____ Primary Registration District No. 3009
City _____ (No. 478, North Spanish) St. _____ Ward _____

2. FULL NAME Alma M. Wheeler
(a) Residence. No. 428 N. Main St. 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 22 - 1924

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>6</u>	<u>2</u>	<u>13</u>	

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) Cape Girardeau
(STATE OR COUNTRY) _____

10. NAME OF FATHER Goeden Wheeler

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

12. MAIDEN NAME OF MOTHER Ivy Patton

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

14. INFORMANT Mr Goeden Wheeler
(Address) 478 North Spanish St.

15. FILED 11/5 1930 W. C. Kumpfer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 4 1930

17. I HEREBY CERTIFY, That I attended deceased from 11/2 1930, to 11/4 1930, and that I last saw her alive on 11/4 1930, and that death occurred, on the date stated above, at 12 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Colitis
120B

(duration) _____ yrs. _____ mos. 3 0

CONTRIBUTORY (SECONDARY) Colitis
(duration) _____ yrs. _____ mos. 3 0

18. WHERE WAS DISEASE CONTRACTED 114-15
IS NOT AT PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Baril Symplest
(Signed) [Signature] M. D.

, 19 _____ (Address) [Signature]

*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 Harmon Cemetery DATE OF BURIAL Nov 5 1930

UNDERTAKER Drunkel Howell ADDRESS 536 Broadway Cape Girardeau

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.

