

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

Do not use this space.

1. PLACE OF DEATH

34 County *Linn*
1 Township *Clinton*
6 City *Quincy* (No.)

Registration District No. *272*
Primary Registration District No. *5379*

File No. *93642*
Registered No.
St. Ward)

2. FULL NAME

(a) Residence. No. *101* St. Ward.

(Usual place of abode) Length of residence in city or town where death occurred *9* yrs. *11* mos. *8* ds. *9* How long in U.S., if of foreign birth? yrs. mos. ds.

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 5 1869*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
61 . *6* . *9*

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *house wife 235*
(b) General nature of industry, business, or establishment in which employed (or employer) *farm wife*
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Mo* (STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER *Dr. A. Wheeler*
11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Mo* (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER *Winters*
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Don't know* (STATE OR COUNTRY) *31*

14. INFORMANT *R. A. Wheeler* (Address) *ava mo*

15. FILED *710* 19 *31* *E. Harman* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *3/15* 19*31*

17. I HEREBY CERTIFY, That I attended deceased from *3-1* 19*31*, to *3-13* 19*31*, and that I last saw her alive on *March 14* 19*31*, and that death occurred, on the date stated above, at *2 a* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of Rectum

Ho J

CONTRIBUTORY (SECONDARY)

46 (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 *Physiognomy*
(Signed) *R. M. Roman* M. D.

, 19 (Address) *ava 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 *North Park* DATE OF BURIAL *JUN 17 1931*

20. UNDERTAKER *Neighbors* ADDRESS

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.

9364-2 JUN 25 1931

WHITE COPY WITH UNFADING INK—THIS IS A PERMANENT RECORD

