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

File No. 8047
Registered No. 391

1. PLACE OF DEATH
County: Callaway
Township: Jackson
City: ..... (No. ..... St. ..... Ward)
Registration District No. 102
Primary Registration District No. 3130

2. FULL NAME John Mason 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: Martha V. Wheeler

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Nov. 6-1848

7. AGE: Years 85 | Months 4 | Days 3. | If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN): Millersburg
(STATE OR COUNTRY): Mo.

PARENTS
10. NAME OF FATHER: Benjamin Wheeler
11. BIRTHPLACE OF FATHER (CITY OR TOWN): .....
(STATE OR COUNTRY): Ky.
12. MAIDEN NAME OF MOTHER: Margaret Fleming
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): .....
(STATE OR COUNTRY): Ky.

14. INFORMANT: Mrs. W. D. Bradley
(Address): Auxvasse, Mo.

15. FILED 3/10, 1934 H. G. Thomas
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Mar. 9 1934.

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1933, to March 9, 1934 that I last saw him alive on March 8, 1934, and that death occurred, on the date stated above, at 9:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral insufficiency
..... (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? No
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) C. B. Nichols, M. D.
, 19 (Address) Auxvasse, 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: Auxvasse, Mo.
DATE OF BURIAL: Mar. 12 1934

20. UNDERTAKER: Hughes Murphin
ADDRESS: Auxvasse

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.