

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
 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.

*Boiley*

DEC 20 1935

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

ALL INFORMATION CALLED  
 FOR MUST BE WRITTEN ON  
 THIS SUPPLEMENTARY.

38415

**1. PLACE OF DEATH**  
 County..... *Webster* ..... Registration District No. *999*  
 Township..... *Jackson* ..... Primary Registration District No. *1905*  
 City..... (No. ....) ..... St. .... Ward)

**2. FULL NAME** *John Austin 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<br><i>M</i>   | 4. COLOR OR RACE<br><i>W.</i> | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)<br><i>Single</i> |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF                                     |                               |  |
| 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Aug 24-1933</i>                                       |                               |  |
| 7. AGE YEARS<br><i>2</i>   | MONTHS<br><i>2</i>            | DAYS<br><i>16</i>  |
| 10. Date deceased last worked at this occupation (month and year) .....                          |                               | 11. Total time (years) spent in this occupation .....                      |
| 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. .... |                               |  |
| 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. ....          |                               |  |
| 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Webster Co. mo</i>                           |                               |  |
| 13. NAME <i>J. A. Wheeler</i>  |                               |  |
| 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Webster Co. mo</i>                           |                               |  |
| 15. MAIDEN NAME <i>Esther Day</i>  |                               |  |
| 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Webster Co. mo</i>                           |                               |  |
| 17. INFORMANT (ADDRESS) <i>Austin Wheeler</i>  |                               |  |
| 18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Pleasant Hill</i> DATE <i>Nov. 18 1935</i>            |                               |  |
| 19. UNDERTAKER (ADDRESS) <i>Wm. Shaw Funeral Service</i>   |                               |  |
| 20. FILED <i>Nov 19 1935</i> <i>C. M. Bailey</i> Registrar                                       |                               |  |

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Nov. 17*, 19*35*

22. I HEREBY CERTIFY, That I attended deceased from *Nov 14*, 19*35*, to *Nov 17*, 19*35*  
 I last saw *him* alive on *Nov 17*, 19*35*. Death is said to have occurred on the date stated above, at *4 P.* m.  
 The principal cause of death and related causes of importance were as follows:  
*Laryngeal Diphtheria*  
 Date of onset *Nov 10*

Other contributory causes of importance:

Name of operation..... Date of.....  
 What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide?..... Date of injury....., 19.....  
 Where did injury occur?..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....  
 If so, specify *Laryngeal Diphtheria*  
 (Signed) *C. M. Bailey*, M. D.  
 (Address) *Elkhead*

