

JUL 26 1937

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

Do not use this space.

23022

1. PLACE OF DEATH

County *Adair*

Registration District No. *9 H*

File No. *23022*

Township *Kirkville*

Primary Registration District No. *3001*

Registered No. *120*

City *Kirkville* (No.)

St. Ward)

2. FULL NAME *Sarah Margriet Wheeler*

(a) Residence, No. *401 E. Baldwin* St., Ward.

(If nonresident, give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred *4* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *June 18, 1937*

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

22. I HEREBY CERTIFY, that I attended deceased from *Mar. 5, 1937* to *June 18, 1937*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *June 22, 1871*

I last saw her alive on *June 18, 1937* Death is said

7. AGE YEARS *65* MONTHS *11* DAYS *26* If LESS than 1 day, hrs. or min.

to have occurred on the date stated above, at *2:00 a.m.*

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *House Keeper*

1. *Cerebral hemorrhage* Date of onset

2. *Arteriosclerosis*

3. *Chronic interstitial nephritis*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation. *Life*

Other contributory causes of importance:

12

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Iowa*

13. NAME *Epharim Burgess*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*

15. MAIDEN NAME *Margaret Cupp*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Not known*

17. INFORMANT (ADDRESS) *Emma Wheeler Kirkville MO*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Waller City* DATE *June 19, 1937*

19. UNDERTAKER (ADDRESS) *Wm W West Waller City MO*

20. FILED *June 18, 1937* *Spencer L. Freeman* Registrar

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? *No*

If so, specify *Spencer L. Freeman*, M. D.

(Signed) *Spencer L. Freeman*, M. D.

(Address) *Kirkville, Mo.*

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.

