

REC'D JUL 12 1938

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

20685

Do not use this space.

1. PLACE OF DEATH

(a) County.....
(b) Township.....
(c) City St. Louis
(e) Length of residence in city or town where death occurred yrs. mos. ds.Registration District No. 791
1008Primary Registration District No. 1160Registered No. 5824(d) Street No. Homer G. Phillips Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Wheeler(a) Residence, No. 1207 Missouri, Ave. St. 22
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 5-29-38
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Mo.FATHER 13. NAME Roy Wheeler14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) UnknownMOTHER 15. MAIDEN NAME Susie Boone16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark.17. INFORMANT (ADDRESS) Cather M. Shepard
2601 N Whittier St.18. BURIAL, CREMATION, OR REMOVAL CITY CEMETERY DATE JUN 30 193819. FUNERAL DIRECTOR (NAME) (ADDRESS) Mrs. Hamilton
City Health Dept20. LOCAL REGISTRAR J. D. Breda
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-29-38 1922. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....
I last saw him alive on 19..... Death is said to have occurred on the date stated above, at 7:06 P. M.
The principal cause of death and related causes of importance were as follows:Stillborn

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....
What test confirmed diagnosis Clinical Was there an autopsy? No23. 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 J. M. Galloway M. D.
(Signed) J. M. Galloway
(Address) 2601 N Whittier St.

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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.