

18-1 X1931  
 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.

Registration District No. 784

Primary Registration District No. 106

Registrar's No. 2019

1. PLACE OF DEATH:  
 (a) County St. Louis  
 (b) City or town Ferguson  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 815 N. Clay 2  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo (b) County St. Louis  
 (c) City or town Ferguson  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 815 N. Clay  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Charles W. Wheeler  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month November day 17 year 1939 hour 7 minute A. M.

4. Sex Male 5. Color or race W  
 6. (a) Single, widowed, married, divorced M.  
 6. (b) Name of husband or wife Mabel Wheeler 6. (c) Age of husband or wife if alive 54 years  
 7. Birth date of deceased Oct 17 1883  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from November 1, 1938, to November 17, 1939 that I last saw him alive on Nov. 16, 1939 and that death occurred on the date and hour stated above.

8. AGE: Years 56 Months 1 Days 0 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Cerebral hemorrhage Duration 1 day  
 Due to Angina Pectoris  
 Due to Hypertension

9. Birthplace St. Louis Co Mo  
 (City, town, or county) (State or foreign country)

10. Usual occupation General Agent

11. Industry or business Texas & Southern R.R.

12. Name Charles Wheeler

13. Birthplace unknown  
 (City, town, or county) (State or foreign country)

14. Maiden name Neese Massey

15. Birthplace unknown  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Mabel Wheeler

(b) Address 815 N. Clay Ferguson

17. (a) Burial (b) Date thereof 11-20-39  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Funeral Home

18. (a) Signature of funeral director Louis Stapp

(b) Address 1001 N. 1st St. St. Louis, Mo.

19. (a) NOV 18 1939 (b) W. R. Meyer  
 (Date received local registrar) (Registrar's signature)

Other conditions 940  
 (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN  
 Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature C. Barnett, M.D. (M. D. or other) \_\_\_\_\_

Address 270 St. Jefferson Date signed Nov. 17, 1939

**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 \_\_\_\_\_

*Louis H Bopp*, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed \_\_\_\_\_

*Louis H Bopp*  
Licensed Embalmer No. *931*

P. O. Address. *Lukwood*

**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.**