

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **17587**
Registrar's No. **2114**

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3534 Highland Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2**
60 Yrs (Specify whether
In this community years, months or days)

8. (a) PRINT FULL NAME **Harry O. WHEELER 460**

8. (b) If veteran, No name war. No
8. (c) Social Security No. **No**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Marie Wheeler** 6. (c) Age of husband or wife if alive **55** years

7. Birth date of deceased **March 24th, 1861**
(Month) (Day) (Year)

8. AGE: Years **79** Months **1** Days **27** If less than one day hr. min.

9. Birthplace **Germany**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Musician.**

11. Industry or business **1**

12. Name **Phillip Wheeler**

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

14. Maiden name **Blairtown**
(City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature **Mrs. Marie Wheeler**
(b) Address **3524 Highland Ave.**

17. (a) **Cremation** (b) Date thereof **5/23/40**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: ~~of~~ cremation **Elmwood Cemetery**

18. (a) Signature of funeral director **Melody-McGilley**
(b) Address **K. C. Mo.**

19. (a) **May 22, 1940** (Date received local registrar)
M. M. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City Mo.**
(If outside city or town limits, write "RURAL")
(d) Street No. **3534 Highland Ave.**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? **60** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **21st**
year **1940** hour **5** minute **A.M.**

21. I hereby certify that I attended the deceased from **About**
one year, 19 **40**, to **May 21**, 19 **40**
that I last saw him alive on **May 20**, 19 **40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Peritonitis** Duration
and chronic myo-
carditis

Due to **430**

Due to

Other conditions (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?

361
While at work? (Specify type of place) Means of injury **!**

23. Signature **Archie W. Johnson** (M. D. or other)
Address **836 Argyle Bldg** Date signed **5/22**

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.

Dr. Archie Johnson
Argyle Bldg.
12th & McGee

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. 2989

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.