

FILED SEP 21 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

30043

State File No. _____

Registration District No. 908

Primary Registration District No. 4549

Registrar's No. 39

1. PLACE OF DEATH:

(a) County Wright
(b) City or town North Grove
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Byram Hospital
(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)

3. (a) PRINT FULL NAME Mary Margarette Wheat

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Thomas Wheat (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 25 1875
(Month) (Day) (Year)

8. AGE: Years 65 Months 3 Days 5 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name George Hafner

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

14. Maiden name Mary Elizabeth

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

16. (a) Informant Thomas Wheat

(b) Address Douglas

17. (a) Burial (b) Date thereof July 31 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Douglas

18. (a) Signature of funeral director Glenn Stapp

(b) Address North Grove Mo.

19. (a) 8-1-1940 (b) Bernice Montgomery
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Douglas
(c) City or town Vanzant (Rural)
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31
year 1940 hour 6 minute 15 a.m.

21. I hereby certify that I attended the deceased from 7/27 to 7/31 1940

that I last saw her alive on 7/31 1940 and that death occurred on the date and hour stated above.

Immediate cause of death ruptured appendix

Due to _____

Due to _____

Other conditions 121
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

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? _____

831 While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature R. Ryan (M. D. or other) _____
Address North Grove Date signed 8-1-40

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 6,

District File Number 940-2614

Date Filed SEP 17 1940

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 George Stopp

Licensed Embalmer No. 3166

P. O. Address 11th St

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

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