

2
3-40
7-39
X23159

Registration District No. 2393 Primary Registration District No. 5314 Registrar's No. _____

1. PLACE OF DEATH:
(a) County Crawford Missouri
(b) City or town near Steelville Mo
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location) 20
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 5 years years, months or days

3. (a) PRINT FULL NAME Louis W Wheelers
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M
6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased 10 1871 (Month) (Day) (Year)

8. AGE: Years 69 Months 2 Days 28 If less than one day _____ min.

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

10. Usual occupation Housewife 9

11. Industry or business _____

12. Name Wing !

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

14. Maiden name _____

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

16. (a) Informant William H Wheeler
(b) Address Steelville Mo

17. (a) _____ (b) Date thereof 9/9-1940 (Month) (Day) (Year)

(c) Place: burial or cremation Burnside buryary

18. (a) Signature of funeral director E J Jones
(b) Address Steelville Mo

19. (a) 10-8-40 (b) W. Jones (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Crawford
(c) City or town Steelville 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 9 day 8 year 1940 hour 4 minute 30 P M.
21. I hereby certify that I attended the deceased from 9-5-40 to 9-8-40 that I last saw her alive on 9-8-40 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to _____
Due to _____

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

Major findings: Of operations _____ Of autopsy _____

Duration 5 days

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? _____

(e) Means of injury _____ (Specify type of place) _____

23. Signature W. Jones (M. D. or other) 1
Address Steelville Mo Date signed 9/8-40

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

MOTHER FATHER

RECEIVED

District Health Officer No. 5,

District File Number 10401024

Date Filed

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.....

Body not Embalmed

Registered Apprentice No.....

working under my personal supervision.

Signed.....

L. J. Jones

Licensed Embalmer No. 2379

P. O. Address Steville Mo

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, fact should be so stated above.