S. No. 2
-11-10-39
5-17-39
I X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34370

Registrar's No. 3883

NOV 12 1940

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: General Hospital #2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9-10-40-10-4-40 (Specify whether years, months or days)

In this community 42 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits write "RURAL")

(d) Street No. 240 9 E. 22nd St.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME George Wheeler

3. (b) If veteran, name war None

3. (c) Social Security No. 495-03-0205

4. Sex Male

5. Color or race Negro

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Bernice Wheeler

6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased 7 (Month) 8 (Day) 1877 (Year)

8. AGE: Years 63 Months 3 Days 1 If less than one day ____ hr. ____ min.

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

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name Calvin Wheeler
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk
(b) Address General Hospital #2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-7-40 (Month) (Day) (Year)
(c) Place: burial or ~~cremation~~ Highland Cemetery

18. (a) Signature of funeral director West, Appleton & Jones
(b) Address 1105 Vine St.

19. (a) 10-7-40 (Date received local registrar) (b) M. M. Grome (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 4 year 40 hour 5 minute 45 P. M.

21. I hereby certify that I attended the deceased from 9-10- 1940 to 10-4- 1940 that I last saw him alive on 10-4- 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
*Pulmonary Tuberculosis	
Due to	
Due to 23	
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature G. C. Thomas (M. D. or other)
Address Gen. Hosp. #2 Date signed 10-5-40

(Licensed Embalmer's Statement on Reverse Side)

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 C. H. Neat

Licensed Embalmer No. 2710

P. O. Address K. C. 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, above space should be left blank.