

NOV 10 1940

Registration District No. 299

Primary Registration District No. 1002

Registrar's No. 3887

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

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 9-24-40-10-3-40
(Specify whether years, months or days) 60 years

3. (a) PRINT FULL NAME John Wheeler

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

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

6. (b) Name of husband or wife Pearl Wheeler 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased 15 1868
(Month) (Day) (Year)

8. AGE: Years 72 Months 2 Days 18 If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business a

MOTHER FATHER { 12. Name Unknown
18. Birthplace Unknown
(City, town, or county) (State or foreign country)
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 (b) Date thereof 10-7-1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Blue Ridge Lawn

18. (a) Signature of funeral director J. W. McCoy
(b) Address 1513 Trapp St.

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

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. 1620 Holmes St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 3
year 40 hour 10 minute 25 A. M.

21. I hereby certify that I attended the deceased from 9-24- 19 40 to 10-3- 19 40
that I last saw im alive on 10-3- 19 40
and that death occurred on the date and hour stated above.

Immediate cause of death (Pulmonary Embolism) Duration
Lung Abscess
Arteriosclerotic Heart Disease

Due to _____

Due to _____

Other conditions 95/15²
(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) Means of injury _____

23. Signature E. C. [Signature] (M. D. or other)
Address Gen. Hosp. #2 Date signed 10-4-40

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 *[Signature]*
Licensed Embalmer No. 3388
P. O. Address K. C. MD.

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.