

No. 2  
1-10-39  
-17-39  
1941

Registration District No. 827

Primary Registration District No. 4500

Registrar's No. 32

1. PLACE OF DEATH:

(a) County Shelby

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

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

(d) Length of stay: In hospital or institution ✓  
In this community all her life (Specify whether years, months or days) 2

3. (a) PRINT FULL NAME Dixie Wheeler

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex Female

5. Color or race W.

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

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

6. (c) Age of husband or wife if alive 71 1/2 years

7. Birth date of deceased Oct 13 - 1895 -  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>45</u>	<u>2</u>	<u>2</u>	hr. _____ min. _____

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

10. Usual occupation housewife

11. Industry or business \_\_\_\_\_

12. Name Sara Oglesby

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

14. Maiden name Edw. Clara Cunningham

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

16. (a) Informant Winnifred Wheeler

(b) Address Clarence Mo

17. (a) Clarence (b) Date thereof 12-16-40  
(Burial, cremation or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maplewood

18. (a) Signature of funeral director W. H. Hopper

(b) Address Clarence Mo

19. (a) 1-9-1941 (b) W. H. Hamilton  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Shelby

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

(d) Street No. 0  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 15  
year 1940 hour 2 minute 30 M.

21. I hereby certify that I attended the deceased from Aug 2  
\_\_\_\_\_ 19 40 to Dec 15 19 40  
that I last saw her alive on Dec 14 19 40  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Breast

Duration 5 months

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

Due to \_\_\_\_\_

Due to 50

Other conditions (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? 751

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury 17th St.

23. Signature D. L. Harlan (M. D. or other) 17th St.  
Address Clarence Mo Date signed Dec 2 1940

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

RECEIVED

District Health Officer No. 10

District File Number 1-41-93

Date Filed JAN 13 1941

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. 3699

P. O. Address Shelburne

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.