

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED JAN 6 1944  
Registration District No. 285

Primary Registration District No. 5977

Registrar's No. 43435

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

1. PLACE OF DEATH:

(a) County Polk  
(b) City or town Aldrich, RI  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Rural Union Township  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution None (Specify whether  
In this community Life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Polk  
(c) City or town Aldrich, Mo RI  
(If outside city or town limits, write "RURAL")  
(d) Street No. Rural Union Township  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

infant not named II

3. (b) If veteran, name war Nil

3. (c) Social Security No. Nil

4. Sex Male 5. Color or Race W

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased November, 8th 1943  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 1 hr. 25 min.

9. Birthplace Polk County Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business Nil

12. Name Phillip Wheeler

13. Birthplace Polk County, Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Helen Cornelly

15. Birthplace Bates County Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Phillip Wheeler

(b) Address Aldrich, Mo RI

17. (a) burial (b) Date thereof 11-9-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mitchell Camp Ground

18. (a) Signature of funeral director [Signature]

(b) Address Walnut Grove, Mo

19. (a) 11-9-43 (b) Rose Stewart  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November, 8th day 8th  
year 1943 hour 5 minute 20 AM M.

21. I hereby certify that I attended the deceased from 4.20 am  
November, 8, 1943, to Nov., 8 (5.20am) 43  
that I last saw him alive on 11-8-, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Nine Weeks Premature  
2nd, of Triplets

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

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

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (Specify type of injury)

23. Signature [Signature] (M. D. 5305)

Address Walnut Grove, Mo Date signed 11-8-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1198

**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.....

Not embalmed....., Registered Apprentice No.....  
working under my personal supervision.

Signed Not Embalmed Genea Dorn

Licensed Embalmer No. 2664

P. O. Address Walnut Grove Wis

**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.**