

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
Mount St. Rose Sanitarium
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wayne

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

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

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME William Wheeler Dennis

3. (b) If veteran, name war Nil

3. (c) Social Security No. None

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

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

7. Birth date of deceased: March 8 1870
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

75	5	24	_____ hr. _____ min.
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9. Birthplace Pocahontas Arkansas
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Unknown

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

14. Maiden name Martha Stevens

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

16. (a) Informant Hugh Fulton

(b) Address Poplar Bluff, Mo.

17. (a) Burial (b) Date thereof 9-5-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenville, Missouri

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) 9-7-45 (b) E.S.M. Hagan
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 2
year 1945 hour 11 minute 30 A.M.

21. I hereby certify that I attended the deceased from Aug 16, 1945, to Sept 2, 1945; that I last saw him alive on Sept 2, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Pyelonephritis interstitial tuberculous, liver, spleen
Due to tuberculous pyelonephritis, bilateral

Duration 2 yrs.

Due to 520

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

Major findings: Of operations _____

Of autopsy Same

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) (e) Means of injury _____

23. Signature John C. Murphy (M. D. or other) M.D.

Address 9121 So. Broadway Date signed 9-2-45

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

16
0
0

95716

Post

115

JAN 29 1946

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 *Elmo R. Sadwell*

Licensed Embalmer No. *4077*

P. O. Address.....

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.