

7. S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

FILED SEP 25 1945
Registration District No. 179

Primary Registration District No. 1002

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:
4340 COLLEGE AVENUE
(If not in hospital or institution, write street number or location)

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

In this community 7 YEARS
years, months or days

3. (a) PRINT FULL NAME MRS BESSIE FERN SCHWANK WHEELER

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE

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

6. (b) Name of husband or wife MR. ALBERT FAYEL WHEELER

6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased: APRIL 11 1900
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>45</u>	<u>4</u>	<u>27</u>	hr. _____ min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business _____

12. Name FRED G. SCHWANK

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

14. Maiden name BERTHA PEITHOOD

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

16. (a) Informant Lena A. Wheeler

(b) Address 7042 Chestnut Ave.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 10 1945
(Month) (Day) (Year)

(c) Place: burial or cremation FOREST HILL CEM.

18. (a) Signature of funeral director D. H. Trucanero

(b) Address 1401 Brush Creek Blvd.

19. (a) 9-10-45 (Date received local registrar) (b) M. D. Holmes (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON

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

(d) Street No. 4340 COLLEGE AVENUE
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT. day 8TH
year 1945 hour 11 minute 15 A.M.

21. I hereby certify that I attended the deceased from 8-26-45
_____ 19, to 9-8-45 19

that I last saw her alive on 9-8-45 19

and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion

Due to Chronic coronary heart disease

Due to _____

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

Major findings: Of operations 9/4

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)

(e) Means of injury _____

23. Signature J. Hodgson (M. D. or other MD)
Address 200 Plaza Med Bldg Date signed 9-8-45

NOV 28 1945

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

A. C. Newcomer Jr.

Licensed Embalmer No. *4043*

P. O. Address *A. C. Newcomer Jr.*

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.