

No. 2  
5-43  
5-17-39  
X36571

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30400

State File No. ....

FILED OCT 12 1945  
Dr. Taylor  
Registration District No. 77

Primary Registration District No. 3016

Registrar's No. 221

1. PLACE OF DEATH:

(a) County Cole

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

(c) Name of hospital or institution:  
St. Mary's Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 weeks  
(Specify whether years, months or days)

In this community 3 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Cole

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

(d) Street No. 306 Jackson  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Errol F. Wheeler

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. 442-07-1556

4. Sex Male ( ) 5. Color or race White

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

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

6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased December 25 1887  
(Month) (Day) (Year)

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

57	9	6	hr.	min.
----	---	---	-----	------

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

10. Usual occupation Mechanic Phillips Petroleum Co.

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

12. Name Osgood P. Wheeler

13. Birthplace Not Known  
(City, town, or county) (State or foreign country)

14. Maiden name Eliza Bailey

15. Birthplace Not Known Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Clara Wheeler

(b) Address Jefferson City, Missouri

17. (a) Burial (b) Date thereof Oct-5-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City, Missouri

18. (a) Signature of funeral director Thos. Gladin

(b) Address Jefferson City, Missouri

19. (a) 10-3-45 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 30  
year 1945 hour 2 minute 45 P.M.

21. I hereby certify that I attended the deceased from Sept 19 to Sept 30 1945  
that I last saw him alive on Sept 30 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Aggravated Toxic Intestinal Hemorrhage  
Due to Rectal abscess

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

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration  
1 wk.  
1 day.  
3 wks.

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? \_\_\_\_\_

(Specify type of place)

While at work? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature H. Kanagawa (M. D. or other) \_\_\_\_\_  
Address 129 E High St Date signed 10/1/45

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

**RECEIVED**

District Health Officer No. 9,

District File Number \_\_\_\_\_

Date Filed \_\_\_\_\_

10-11-45

**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 \_\_\_\_\_

working under my personal supervision.

Registered Apprentice No. \_\_\_\_\_

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. oet  
Registrar's No. 221

Registration District No. 27

Primary Registration District No. 3016

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

1. PLACE OF DEATH:

(a) County Cole  
(b) City or town Jefferson city  
(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 \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Enol F Wheeler

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

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

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

7. Birth date of deceased Dec 25 (Month) (Day) (Year)

8. AGE: Years 57 Months \_\_\_\_\_ Days \_\_\_\_\_ if less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 10-3-45 (b) (R.P. Davis md)  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 10 Year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I first saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

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)

(b) 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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

FEB 1 1986

30400