

FILED MAY 17 1946
STANDARD CERTIFICATE OF DEATH

State File No. **19042**
Registrar's No. **4114**

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Mary's Inf.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **15 days**
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME **Zettie Wheeler**
3. (b) If veteran, **No** **3. (c) Social Security** **No**
4. Sex **Female** **5. Color or** **Col.** **6. (a) Single, widowed, married,** **Married**
6. (b) Name of husband or wife **Samuel Wheeler** **6. (c) Age of husband or wife if** **24th.** **1892**
7. Birth date of deceased **Jan.** **24th.** **1892**
(Month) (Day) (Year)

8. AGE: Years **54** Months **3** Days **9** If less than one day
hr. min.

9. Birthplace **Miss.**
(City, town, or county) (State or foreign country)
10. Usual occupation **Housewife**

11. Industry or business **Berry Farr**
12. Name **Berry Farr**
13. Birthplace **Miss.**
(City, town, or county) (State or foreign country)
14. Maiden name **Jane** **(?)**
15. Birthplace **Miss.**
(City, town, or county) (State or foreign country)
16. (a) Informant **Samuel Wheeler**
(b) Address **1322 Bond Avenue**
17. (a) Removal **(b) Date thereof** **5-10-1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Forced Miss. Miss.**
18. (a) Signature of funeral director **W. J. Redbeck**
(b) Address **1318 E. Broadway**
19. (a) MAY 6 1946 **(b) Registrar's signature** **J. F. Redbeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Illinois** (b) County **St. Clair**
(c) City or town **E. St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **1322 Bond 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 **May** day **3rd.**
year **1946** hour **2** minute **30 P.M.**
21. I hereby certify that I attended the deceased from **March 15**
46 to **April 2** **1946**
that I last saw her alive on **April 2** **1946**
and that death occurred on the date and hour stated above.
Immediate cause of death **Nephritis Chronic**
Uremia Duration

Due to **131**
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
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) (c) Means of injury
23. Signature **Edgar F. Woodson** **(M. D. or other)** **0930 N 2nd** **5/4/46**
Address **Woodson** Date signed

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

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 *D. W. Green*
Licensed Embalmer No. 1173
P. O. Address 357 Sackville St.

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. JuneRegistrar's No. 7117Registration District No. 318Primary Registration District No. 1003

1. PLACE OF DEATH:

- (a) County St Louis
(b) City or town St Louis
(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 Lette Wheeler

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

4. Sex 7 5. Color or race B 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 Jan 2
(Month) (Day) (Year)
8. AGE: Years 54 Months 3 Days 2 (If less than one day)
hr. _____ min. _____

9. Birthplace Miss
(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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (c) Signature of funeral director _____

- (b) Address _____

19. (a) May-6-1946 (b) J. F. Bridgman
(Date received local registrar) (Signature)
MAY 23 1946

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 _____ Year 1946 Hour _____ Minute _____ M. 3

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him _____ live 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 _____

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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)
(c) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

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