No. 2
5-43
17-39
X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 29 1947

Registration District No. 373

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 43720

Primary Registration District No. 6267

Registrar's No.

1. PLACE OF DEATH:

(a) County Webster

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

(c) Name of hospital or institution: x
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution x (Specify whether
In this community life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Webster 112

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

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

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

If yes, name country x

3. (a) PRINT FULL NAME Lawrence Winton Wheeler

3. (b) If veteran, name war x

3. (c) Social Security No. x

4. Sex Male

5. Color or race White

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

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

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased September - 2 - 1884
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
62	3	20	x hr. x min.

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

10. Usual occupation Farmer

11. Industry or business Farm

FATHER
12. Name H. C. Wheeler
13. Birthplace Unknown
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Cunningham
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Eva Wheeler
(b) Address Elkland, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-46
(Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ Pleasant View

18. (a) Signature of funeral director [signature]
(b) Address Marshfield, Missouri

19. (a) 2/5/47 (Date received local registrar) (b) J. G. McKinney (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month December day 22
year 1946 hour 8 minute 45 P.M.

21. I hereby certify that I attended the deceased from 18 Dec. 1946 to 21 Dec. 1946, that I last saw him alive on 21 Dec. 1946, and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage, cerebral acute, severe, c right-sided hemiplegia.

Due to Hypertension, arteriolosclerotic, chronic, severe.

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings: Of operations NONE

Of autopsy NONE

83A

Duration

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? (e) Means of injury

23. Signature S. E. Schlicht M.D. (M. D. or other)

Address NIANGUA, MO. Date signed 4 JAN. 47

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(Licensed Embalmer's Statement on Reverse Side)

JAN 29 1947

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 Rex Ramey

Licensed Embalmer No. 3312

P. O. Address Marshfield, Mo.

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.

No. 2B
3-45
X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 7

Registration District No. 373 Primary Registration District No. 6267 Registrar's No.

1. PLACE OF DEATH:

(a) County: Webster

(b) City or town: Rural
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME: Lawrence W. 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: Sept (Month) 2 (Day) 1884 (Year)

8. AGE: Years 62 Months 3 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 2/5/47 (Date received local registrar) (b) J. H. McKinney (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day 22 year 1946 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

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 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? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

S-43720