

Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **492**

1. PLACE OF DEATH:

(a) County **Buchanan**
(b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **518 North 3 St 1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **35 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan**
(c) City or town **St. Joseph**
(If outside city or town limits, write "RURAL")
(d) Street No. **518 N. 3 St.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **1**
year **1947** hour **12** minute **28** p. M.

21. I hereby certify that I attended the deceased from **March 30**, 19**47**, to **April 1**, 19**47**
that I last saw h **im** alive on **April 1**, 19**47**
and that death occurred on the date and hour stated above:

Immediate cause of death **Cerebral Haemorrhage** Duration **30 hrs**

Due to **Chronic Hypertension Unknown**
But from history given 2 Yrs

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) (e) Means of injury _____

23. Signature **J. D. Sertore** (M. D. or _____)
Address **1923 Messanie St.** Date signed **4-31-47**

3. (a) PRINT FULL NAME **EPHRAIM WHEELER**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **491-10-9971**

4. Sex **male** 5. Color or race **negro** 6. (a) Single, widowed, married. **2 divorced widowed**

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

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

8. AGE: Years **60** Months **1** Days **6** If less than one day _____ hr. _____ min.

9. Birthplace **Little Rock Arkansas**
(City, town, or county) (State or foreign country)

10. Usual occupation **Labor**

11. Industry or business **unknown**

MOTHER FATHER

12. Name **unknown** **9**

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

14. Maiden name **unknown**

15. Birthplace **unknown** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Maryne Smith**

(b) Address **2318 Angeleque St**

17. (a) **Burial** (b) Date thereof **April 5-1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Ashland Cemetery**

18. (a) Signature of funeral director **Beatrice Jones**

(b) Address **812 Pacific St - St. Joseph, Mo.**

19. (a) **4-10-47** (b) **B. L. Jenkins**
(Date received local registrar) (Registrar's signature)

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

25x

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

Earl A. Clark

Licensed Embalmer No.

4238

P. O. Address

St. Joseph, 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.