

FILED APR 15 1947

Registration District No. 339

Primary Registration District No. 6149

Registrar's No. 316

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

1. PLACE OF DEATH:

(a) County Stoddard

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

(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None
(Specify whether)

In this community 10 yrs
years, months or days

3. (a) PRINT FULL NAME Charles W. Wheeler

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 5. Color or race Wh. 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive 5 years

7. Birth date of deceased March 1st 1874
(Month) (Day) (Year)

8. AGE: Years 73 Months 0 Days 24 If less than one day
hr. min.

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

10. Usual occupation Retired

11. Industry or business

12. Name Barlow Wheeler

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

14. Maiden name Leant Turner

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

16. (a) Informant W. W. Wheeler

(b) Address Wendley R.

17. (a) Burial (b) Date thereof 3-25-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wendley Cem.

18. (a) Signature of funeral director Street Road, Or.

(b) Address Or.

19. (a) 3-27-47 (b) Floyd Morgan
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard

(c) City or town Wendley R.
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 24
year 1947 hour 5 minute 30 P. M.

21. I hereby certify that I attended the deceased from 3-10, 1947, to 3-24, 1947
that I last saw him alive on 3-10, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma sigmoid

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy No

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) None

(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 F. J. Davis (M. D. or other) _____

Address Or. Date signed 3-25-47

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Office No. 2,

District File Number 447-548

Date Filed 7-10-47

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.

District File Number.....

RECEIVED
District Health Office No. 2,

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.