

No. 300  
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FEDERAL BUREAU OF INVESTIGATION  
National Office of Vital Statistics  
**FILED APR 23 1948**  
Registration District No. 318

MISSOURI DIVISION OF HEALTH  
**STANDARD CERTIFICATE OF DEATH**

State File No. 14770  
Registrar's No. 3536

Primary Registration District No. 1003

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

**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:  
Enroute City Hospital  
(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)

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3: (a) PRINT FULL NAME..... Albert Jackson Wheat

3: (b) If veteran, name war..... Unknown | 3: (c) Social Security No. .... Unknown

4. Sex Male | 5. Color or race..... White

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

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

7. Birth date of deceased..... ? ? 1898  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>50</u>	<u>?</u>	<u>?</u>	.....hr. ....min.

9. Birthplace..... Pine Bluff Arkansas  
(City, town, or county) (State or foreign country)

10. Usual occupation..... unh.

11. Industry or business.....

MOTHER FATHER { 12. Name..... John Wheat

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

14. Maiden name..... Maggie Quattlebaum

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

16. (a) Informant..... Mrs. Harry Levine

(b) Address..... Pine Bluff, Arkansas

17. (a) Removal (b) Date thereof..... 4-12-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... Pine Bluff, Ark.

18. (a) Signature of funeral director..... Albert H. Hoppe

(b) Address..... 4700 Washington Blvd.

19. (a) APR 13 1948 (b) J. G. Brebeck  
(Data received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County..... 000

(c) City or town..... St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 522 Chestnut St.  
25 (If rural, give location)

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

If yes, name country.....

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month April day 10  
year 1948 hour 6 minute 50 P.M.

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

Immediate cause of death..... Gastric hemorrhage due to new growth in cardiac end.

Due to..... Malignant heart growth

Due to.....

Other conditions (include pregnancy within 3 months of death)..... 55

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) & Means of injury..... 3

23. Signature..... Patrick E. Taylor (M.D. or other)  
Address..... By Courier Date signed..... 4/12/48

3-36

**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 Gustav W. Dietrich  
Licensed Embalmer No. 4329  
P. O. Address St. Louis, 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.**

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....  
(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)

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 Albert J. Wheat

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 S

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

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

8. AGE: Years 50 Months 2 Day 2 If less than one day..... hr. min.

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

10. Usual occupation Unknown

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) (Date received local registrar)..... (b) J. F. Bredack (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April year 1948 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to..... 19..... that I last saw him..... alive on..... 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:

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(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.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE PERMANENT RECORD

S-14770

Ro-5500