

FILED JAN 29 1949

STANDARD CERTIFICATE OF DEATH

State File No. 3391  
346

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY DAN	
b. CITY (If outside corporate limits, write RURAL, and give township) OR TOWN ST LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		e. STREET ADDRESS (If rural, give location) 2212 Spruce, ST	

3. NAME OF DECEASED (Type or Print)	a. (First) Irene	b. (Middle) ...	c. (Last) Miller Wheeler	4. DATE OF DEATH (Month) (Day) (Year)	1 9 49
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5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Widowed	8. DATE OF BIRTH 2-2-1897	9. AGE (In years last birthday) 51	10. UNDER 1 YEAR Months	11. UNDER 12 HRS. Hours	12. UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) UTAH. AIA	12. CITIZEN OF WHAT COUNTRY? AIA
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13a. FATHER'S NAME WATT WILLIAMS	13b. MOTHER'S MAIDEN NAME Easter Rose	14. NAME OF HUSBAND OR WIFE Widowed
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs. Chora Halber	18. ADDRESS 2204 Spruce
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Undet.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Heart Disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Undetermined DUE TO (c) Chronic Glomerular Nephritis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Chronic Glomerular Nephritis	Undet.

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) No	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 12-31, 1948, to 1-9, 1949, that I last saw the deceased alive on 1-9, 1949, and that death occurred at 5 a. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Adair L. Daniels M. D.	23b. ADDRESS 2601 N Whittier	23c. DATE SIGNED 1/10/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1-15-49	24c. NAME OF CEMETERY OR CREMATORY Washington Park	24d. LOCATION (City, town, or county) (State) St. Louis, Mo
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JAN 12 1949 J. B. Parater	25. GENERAL DIRECTOR'S SIGNATURE, ADDRESS Bernell on 3103 Washington
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WRITE PLAINLY—USING 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 \_\_\_\_\_

.....  
working under my personal supervision.

Student Embalmer No. ....

Signed.....  
Student Embalmer

Signed *W. Claude Gordon*

Licensed Embalmer No. *9489*

P. O. Address *4575 Aldene*

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.