

FILED MAY 13 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **11511**BIRTH NO. _____ REG. DIST. NO. **37** PRIMARY REG. DIST. NO. **5119** Registrar's No. **21**

1. PLACE OF DEATH a. COUNTY Boone		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE Mo. b. COUNTY Boone	
b. CITY OR TOWN Rural -		c. CITY (If outside corporate limits, write RURAL and give township) Centralia, Mo.	
c. LENGTH OF STAY (If in this place)		d. STREET ADDRESS (If rural, give location) 316 South Polk's	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED a. (First) William b. (Middle) A. c. (Last) Wheeler			4. DATE OF DEATH (Month) (Day) (Year) April - 15 - 1949		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	
8. DATE OF BIRTH May 2 - 1894		9. AGE (In years last birthday) 54		10. IF UNDER 1 YEAR: Months 11 Days 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Engineer		11. BIRTHPLACE (State or foreign country) Boone Co. Mo.	
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME Frank Wheeler		14. MOTHER'S MAIDEN NAME Maud Wheeler	
15. NAME OF HUSBAND OR WIFE		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) World War No. 1.		17. SOCIAL SECURITY NO. 510-01-0506	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
<p>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis				4201	
		ANTECEDENT CAUSES					
		DUE TO (b) Chronic Hypertension DUE TO (c) Hypertensive Regeneration					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

21a. ACCIDENT SUICIDE HOMICIDE (Specify) X		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) X		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 2:30 p.m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 5-9-45 , to 4-15-49 , that I last saw the deceased alive on 4-5-49 , and that death occurred at 9:15 A.M. , from the causes and on the date stated above.					
23a. SIGNATURE J. O. Baker, D.O. (Degree or title)		23b. ADDRESS Centralia Mo.		23c. DATE SIGNED 4-18-49	

24a. BURIAL, CREMATION, OR REMOVAL (Specify)		24b. DATE April 18, 1949		24c. NAME OF CEMETERY OR CREMATORY Centralia Mo.		24d. LOCATION (City, town, or county) (State) Centralia Mo.	
DATE REC'D BY LOCAL REG. April 18/49		REGISTRAR'S SIGNATURE Maud Mc Bride		30. GENERAL DIRECTOR'S SIGNATURE Henry J. ...		ADDRESS	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD—10000

11/12/21/1949

Date Filed MAY 12 1949

District File Number

District Health Officer No. 9,

RECEIVED

MAY 13 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed

Gene Johnson

Signed.....

Student Embalmer

Licensed Embalmer No.

4570

P. O. Address

Centerville 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.