

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

State File No. 27617
 BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 274 PRIMARY REG. DIST. NO. 3052 Registrar's No. 262

1. PLACE OF DEATH a. COUNTY <u>PELTIE</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>ARKANSAS</u> b. COUNTY <u>UNKNOWN</u>		
b. CITY (If outside corporate limits, write RURAL and give town) <u>SEDALIA</u>		c. LENGTH OF STAY (If this place) <u>11 days</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>VAN BUREN</u>		d. STREET ADDRESS (If rural, give location) <u>1503 Poplar</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>BOTHWELL MEMORIAL HOSPITAL</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>JOSEPH</u> b. (Middle) <u>EUGENE</u> c. (Last) <u>WHEELER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 31 1949</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 20 1917</u>		9. AGE (In years last birthday) <u>31</u> IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u> IF UNDER 24 HRS. Hours <u>9</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet-Metal Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MOPacific R.R. Co</u>	11. BIRTHPLACE (State or foreign country) <u>Knobnoster, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Joe R. Wheeler</u>		13b. MOTHER'S MAIDEN NAME <u>Maude Stevens</u>		14. NAME OF HUSBAND OR WIFE <u>Thelma E. Wheeler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>World War II</u>		16. SOCIAL SECURITY NO. <u>702-16-1684</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Thelma E. Wheeler, 1503 Poplar, VanBuren</u>		
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Poliomyelitis, acute, bulbar</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____				INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u>
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<u>0810</u>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.	21e. INJURY OCCURRED WHILE AT <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 <u>20 July, 1949</u> , to <u>31 July, 1949</u> , that I last saw the deceased alive on <u>31 July, 1949</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <u>D. R. Edwards, M.D.</u>			23b. ADDRESS <u>Sedalia, Mo.</u>		23c. DATE SIGNED <u>31 July 1949</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Aug 2, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	24d. LOCATION (City, town, or county) (State) <u>Sedalia, Missouri</u>		
DATE REC'D BY LOCAL REG. <u>8-2-49</u>	REGISTRAR'S SIGNATURE <u>Betty Yeager Deputy</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Heckart</u>		ADDRESS <u>Sedalia, Mo.</u>

(Licensed Embalmer's Statement on Reverse Side)

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

MAR 21 1950

RECEIVED AUG 8 1949

District Health Officer (No. 10)

District File Number \_\_\_\_\_

Date Filed 8-15-49

MAY 3 1950

AUG 16 1949

SEP 17 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 [Signature]

Licensed Embalmer No. 3470

P. O. Address Sedalia, Mo

Signed \_\_\_\_\_  
Student Embalmer

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.