

FILED JAN 21 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1421

BIRTH NO.		REG. DIST. NO. 149	PRIMARY REG. DIST. NO. 1003	Registrar's No. 29
1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. LENGTH OF STAY (in this place) 60 yrs.		
d. FULL NAME OF HOSPITAL OR INSTITUTION 4206 Bell St.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		
		d. STREET ADDRESS (If rural, give location) 4206 Bell		
3. NAME OF DECEASED (Type or Print) a. (First) ELIZABETH		b. (Middle) LOUISE		c. (Last) WHEELER
		4. DATE OF DEATH		(Month) (Day) (Year) Jan. 1 1950
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 12/15/1881	9. AGE (In years last birthday) 68
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (State or foreign country) Rosedale, Kansas	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME Dr. J.E. Moses		13b. MOTHER'S MAIDEN NAME Elizabeth Jones		14. NAME OF HUSBAND OR WIFE Mr. H.W. Wheeler
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. H.W. Wheeler, K.C. Missouri
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) Pernicious Anemia Arteriosclerosis 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.		
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)		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) (Min)		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 1937, to Jan 1, 1950, that I last saw the deceased alive on 12/31/1949, and that death occurred at 4:42 a.m., from the causes and on the date stated above.				
23a. SIGNATURE Edson C. Carrow, M.D. (Degree or title)		23b. ADDRESS 242 Plaza Md. Bldg		23c. DATE SIGNED 1/1/50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1-4-50	24c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery	24d. LOCATION (City, town, or county) (State) Kansas City, Missouri
DATE REC'D BY LOCAL REG. 1-4-50		REGISTRAR'S SIGNATURE Geraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS GATES FUNERAL HOME, K.C. KANSAS

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Jimmy S. Huckscher*
Licensed Embalmer No. *4092*

P. O. Address *Missouri, Kansas*

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.