

FILED APR 19 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13394
Registrar's No. 33

BIRTH NO. _____ REG. DIST. NO. 140 PRIMARY REG. DIST. NO. 3024

1. PLACE OF DEATH

a. COUNTY Howard

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fayette

c. LENGTH OF STAY (in this place) 4 Wks

d. FULL NAME OF HOSPITAL OR INSTITUTION Lee Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

a. STATE Missouri

b. COUNTY Randolph

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Higbee 0880

d. STREET ADDRESS (If rural, give location) 1

3. NAME OF DECEASED

a. (First) Jessie

b. (Middle) McClausland

c. (Last) Wheeler

4. DATE OF DEATH (Month) (Day) (Year) Apr. 10, 1951

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH May 31, 1871

9. AGE (In years last birthday) 79

If UNDER 1 YEAR: 10 Months 9 Days

If UNDER 1 HR.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Randolph County Mo.

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME John McClausland

13b. MOTHER'S MAIDEN NAME Sallie Snell

14. NAME OF HUSBAND OR WIFE Tom Wheeler

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 Frances Owens

ADDRESS St Louis, Mo

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, asthma, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertension & Diabetes.

INTERVAL BETWEEN ONSET AND DEATH 5 yrs 75

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 NO

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) _____

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR _____

22. I hereby certify that I attended the deceased from June 1, 1946, to April 10, 1951, that I last saw the deceased alive on April 9, 1951, and that death occurred at 6:07 P.M., from the causes and on the date stated above.

23a. SIGNATURE Mr. J. Shaw M.D. (Degree or title)

23b. ADDRESS Fayette, Mo.

23c. DATE SIGNED 4-11-51

24a. BURIAL, CREMATION, REMOVAL Removal

24b. DATE 4/11/51

24c. NAME OF CEMETERY OR CREMATORY Higbee Cemetery

24d. LOCATION (City, town, or county) (State) Higbee, Mo

DATE REC'D BY LOCAL REG. 4-11-51

REGISTRAR'S SIGNATURE Mary K. Snell 436

25. FUNERAL DIRECTOR'S SIGNATURE Ralph A. Carr

ADDRESS Fayette, Mo

(Licensed Embalmer's Statement of Reverse Side)

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

45
0

RECEIVED 4-18-51

DISTRICT HEALTH OFFICE No. 3

District File Number

Date Filed 4-18-51

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 Ralph A. Carr
Licensed Embalmer No. 3340

P. O. Address Fayette 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.