

FILED AUG 29 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26047

BIRTH NO. _____		REG. DIST. NO. <u>1</u>	PRIMARY REG. DIST. NO. <u>3000</u>	Registrar's No. <u>231</u>
1. PLACE OF DEATH a. COUNTY <u>Adair 0013</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Adair</u>		
b. CITY OR TOWN <u>Kirksville</u>		c. CITY OR TOWN <u>Kirksville 0013</u>		d. FULL NAME OF HOSPITAL OR INSTITUTION. <u>912 - W - Gardner</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION. <u>912 - W - Gardner</u>		d. STREET ADDRESS (If rural, give location) <u>912 - W - Gardner 0</u>		
3. NAME OF DECEASED (Type or Print) (First) <u>David</u> (Middle) <u>B.</u> (Last) <u>Wheeler</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>8 - 20 - 51</u>		
5. SEX <u>Mo</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>May 16 1885</u>	9. AGE (In years last birthday) <u>66</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Martinstown, Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Abel Wheeler</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Bucklew</u>	14. NAME OF HUSBAND OR WIFE <u>Mary Stober</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Fred Wheeler</u> ADDRESS <u>Kirksville Mo</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</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 _____
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) _____	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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>2:50</u> p. m., from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) <u>Robert B. Davis Coroner</u>		23b. ADDRESS <u>Adair Co. Mo.</u>		23c. DATE SIGNED <u>8-20-51</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>8-23-51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Morselock Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Adair Co. Mo.</u>	
DATE REC'D BY LOCAL REG. <u>8-23-51</u>	REGISTRAR'S SIGNATURE <u>Hate Lambert's</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert B. Davis</u> ADDRESS <u>Kirksville, Mo.</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

Date Received: **AUG 28 1951**
DISTRICT HEALTH OFFICE #2
District File Number *8-51-1520*
Date Filed: **AUG 28 1951**

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 *Robert B. Davis*

Signed.....
Student Embalmer

Licensed Embalmer No. *#219*

P. O. Address *Kiskadee, 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.