

FILED OCT 19 1953

STANDARD CERTIFICATE OF DEATH

State File No.

BIRTH NO. 28720 REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 950

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY GREENE <u>0390</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPRINGFIELD		c. CITY OR TOWN SPRINGFIELD	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (In this place) 30 MINUTES		e. STREET ADDRESS (If rural, give location) RURAL ROUTE 6	
d. FULL NAME OF HOSPITAL OR INSTITUTION BURGE HOSPITAL			

3. NAME OF DECEASED (Type or Print)	a. (First) DONALD	b. (Middle) CAMERON	c. (Last) WHEELER	4. DATE OF DEATH (Month) (Day) (Year)
				10 10 53

5. SEX M	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH 5 5 1953	9. AGE (In years last birthday) Months Days Hours Min. - - 5 5
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (City and State or Foreign Country) SPRINGFIELD, MISSOURI <u>0</u>	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME GORDON WHEELER	13b. MOTHER'S MAIDEN NAME LUCY LAFFERTY	14. NAME OF HUSBAND OR WIFE NONE
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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. LUCY WHEELER	ADDRESS RR 6
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ??? <i>Strangulation - while taking medication shortly after AM. today.</i>		?-3 hrs.
ANTECEDENT CAUSES	DUE TO (b) Diarrhea - fermentative		2 days.
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	9227 46	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) 039 (STATE)
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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
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22. I hereby certify that I attended the deceased from 8 Oct, 1953, to 10 Oct, 1953, that I last saw the deceased alive on 10 Oct 53, and that death occurred at 2:45 P.M., from the causes and on the date stated above.

23a. SIGNATURE Harold E. Keable M.D. (Degree or title)	23b. ADDRESS Springfield Mo.	23c. DATE SIGNED 10 Oct 53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct-12, 1953	24c. NAME OF CEMETERY OR CREMATORY Dishman Cemetery	24d. LOCATION (City, town, or county) (State) Greene County, Missouri
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DATE REC'D BY LOCAL REG. 10-13-53	REGISTRAR'S SIGNATURE Edith Williamson	25. FUNERAL DIRECTOR'S SIGNATURE J.W. Klingner & Co.	ADDRESS Springfield, Mo
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WRITE PLAINLY--USING UNFAADING 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.....
Signature of Student Embalmer

Signed *Max Rhodes*.....

Licensed Embalmer No. *407*.....

P. O. Address *Spring*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.