

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9788

FILED APR 10 1957

STATE FILE NUMBER

Registration District No. 314 Primary Registration District No. 4457 Registrar's No. 14

1. PLACE OF DEATH a. COUNTY <u>ST. CLAIR</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. CLAIR</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>OSCEOLA</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>PRAIRIE-OSCEOLA</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Todds Hospital</u> Length of stay in lb <u>6 days</u>		d. STREET ADDRESS (If outside, give location) <u>DALLAS TOWNSHIP</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>EUGENE</u> Middle <u>RAY</u> Last <u>WHEELER</u>			4. DATE OF DEATH Month <u>MAR</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 10, 1910</u>	9. AGE (In years last birthday) <u>46</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Guiney Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>GUSTAVUS WHEELER</u>			14. MOTHER'S MAIDEN NAME <u>EMMA WHEELER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs Ray WHEELER - OSCEOLA MO</u>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral concussion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Skull fracture (left temporal area)</u>	
	DUE TO (c) <u>Automobile accident</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident 3-21-57 @10:15P.M. on HwyA 3mi. West Lowry City</u>	
20c. TIME OF INJURY Hour <u>10:15</u> Minute <u>15</u> Month, Day, Year <u>3-21-57</u>		Mo. <u>Mo.</u>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>Mo. State Highway A</u>	
20f. CITY, TOWN, OR LOCATION <u>073</u> COUNTY <u>ST. CLAIR</u> STATE <u>MO.</u>		3 Mi. west Lowry City, St. Clair Mo.	

21. I attended the deceased from <u>3-21-57</u> to <u>3-27-57</u> and last saw <u>DEF</u> alive on <u>3-27-57</u> Death occurred at <u>10:30 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>H.L. Shipman, D.O.</u>		22b. ADDRESS <u>Osceola, Mo.</u>	22c. DATE SIGNED <u>3-28-57</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>MAR 30 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>KINGS PRAIRIE</u>	23d. LOCATION (City, town, or county) (State) <u>OSCEOLA MO</u>
24. FUNERAL DIRECTOR ADDRESS <u>Goodrich 7, HOME - OSCEOLA MO</u>		25. DATE RECD. BY LOCAL REG. <u>3-30-57</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Seever</u>

(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare
 Public Service
 S. 300
 1-56
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.
 Securing the medical certificate in the specific manner required by 192.140 must be used.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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MAR 19 1958

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 *J. B. Bandrich*
Licensed Embalmer No. *3031*

P. O. Address *Osceola*

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.