

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-043339

STATE FILE NUMBER

FILED DEC 29 1958

Registration District No. 042

Primary Registration District No. 1000

Registrar's No. 1360

300
1-57

1. PLACE OF DEATH a. COUNTY BUCHANAN			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY BUCHANAN		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. JOSEPH		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST. JOSEPH		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION MC. METHODIST HOSPITAL		Length of stay in lb 14 MONTHS	d. STREET ADDRESS (If outside, give location) 5612 SO. 11th St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First LOVELL Middle R. Last WHEELER			4. DATE OF DEATH Month Dec. Day 16, Year 1958		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 10, 1868	9. AGE (In years of birthday) 90	IF UNDER 1 YEAR Months 1 Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	11. BIRTHPLACE (City and state or country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME W. R. WHEELER		13b. MOTHER'S MAIDEN NAME MARY RAYBURN		14. NAME OF HUSBAND OR WIFE LOUIE WHEELER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <input type="checkbox"/> No <input checked="" type="checkbox"/> unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT WILLIAM WHEELER Address ST. JOSEPH, MO. 5612 SO. 11TH ST.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right Cerebral Thrombosis					INTERVAL BETWEEN ONSET AND DEATH 5 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Arteriosclerosis Cerebral					unknown
DUE TO (c) Arteriosclerosis					unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic Heart Disease					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input 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.) 332X		
20c. TIME OF INJURY Hour 10:30 Month, Day, Year 1958 a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Nov 23, 1957 to Dec 16 1958 and last saw ^{her} him alive on Dec 16, 1958 Death occurred at 10:30 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Sharon E. Waggoner M.D.</i>			22b. ADDRESS 301 Illinois Ave St. Joseph, Missouri		22c. DATE SIGNED 12/17/58
23a. BURIAL, CREMATION, REBURYAL (Specify) BURIAL	23b. DATE Dec. 20, 58	23c. NAME OF CEMETERY OR CREMATORY SAVANNAH CEMETERY		23d. LOCATION (City, town, or county) (State) SAVANNAH, MISSOURI	
24. FUNERAL DIRECTOR CLARK FUNERAL HOME, ST JOSEPH, MO.		ADDRESS		25. DATE RECD. BY LOCAL REG. Dec. 22, 1958	26. REGISTRAR'S SIGNATURE <i>Wm. Clark Standell</i>

All diseases in Part I must be causally related.
 Dr. Sharon E. Waggoner
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Allan E. Boman*
Licensed Embalmer No. *4795*
P. O. Address *St Joseph 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.