

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018659
STATE FILE NUMBER

FILED MAY 18 1959

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 161

300
1-57

1. PLACE OF DEATH a. COUNTY <u>PETTIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>PETTIS</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SEDALIA</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>LA MONTE</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>CAMPBELL NURSE HOME</u>			Length of stay in 1b <u>1 YEAR.</u>	d. STREET ADDRESS <u>0800 South. WALNUT ST.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA LEE WHEELER.</u>				4. DATE OF DEATH Month Day Year <u>5-9-1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-29-1866</u>	9. AGE (In years last birthday) <u>93</u>	F UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	11. BIRTHPLACE (City and state or country) <u>LA MONTE MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>JOHN S. FLEMING</u>			13b. MOTHER'S MAIDEN NAME <u>EWEZEBETH RUTSON</u>		14. NAME OF HUSBAND OR WIFE <u>R. H. WHEELER.</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. <u>NONE</u>	17. INFORMANT Address <u>J. ELMO WHEELER - LA MONTE 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>Pulmonary edema</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last. DUE TO (b) <u>Senility</u>						<u>5 years</u>	
DUE TO (c) <u>Parkinson's Disease 350X</u>						<u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Abdominal mass. Etiology not determined</u>						19. WAS AUTOPSY PERFORMED? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.							
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK		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 <u>April 16, 1958</u> to <u>9 May 1959</u> and last saw her <u>alive</u> on <u>7 May 1959</u> Death occurred at <u>11 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Stanley D. Fisher M.D.</u>				22b. ADDRESS <u>500 St. 16th Sedalia, Mo.</u>		22c. DATE SIGNED <u>5-11-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>5-12-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LA MONTE CEMETERY</u>		23d. LOCATION (City, town, or county) <u>LA MONTE</u>		(State) <u>MO</u>
24. FUNERAL DIRECTOR ADDRESS <u>Paul M. Moore - La Monte Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>5/12/1959</u>		26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u>		

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Paul M. Moore*

Licensed Embalmer No. *3923*
P. O. Address *La Monte 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.