

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-022553

GIVEN JUL 13 1959

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 164

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Charles</u> Length of stay in 1b <u>3 Days</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph's Hosp.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u> c. CITY OR TOWN <u>St. Ann</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>3601 San Jose</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>R.</u> Last <u>Wheeler</u>			4. DATE OF DEATH Month <u>7-</u> Day <u>7</u> Year <u>59</u>				
5. SEX <u>Male</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>12-26-1877</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Shoe Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe Factory</u>		11. BIRTHPLACE (City and state or country) <u>Lebanon, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Russell Wheeler</u>			13b. MOTHER'S MAIDEN NAME <u>Florence Rye</u>			14. NAME OF HUSBAND OR WIFE <u>The late Josphine Wheeler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes Spanish Amr</u>		16. SOCIAL SECURITY NO. <u>493-01-1937</u>		17. INFORMANT Address <u>Florence Fierst 3613 St. Marguerite</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 Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio sclerosis</u> DUE TO (c) <u>Hyper Tension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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.)				
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		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 <u>Sept. 1955</u> to <u>July 7, 1959</u> and last saw ^{her} him alive on <u>7-7-59</u> Death occurred at <u>11:55 P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>W. G. McElharty, M.D.</u>				22b. ADDRESS <u>8711 St. Charles</u>		22c. DATE SIGNED <u>7/8/59</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7-10-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Collier Mortuary St. Ann, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>July 10-59</u>		26. REGISTRAR'S SIGNATURE <u>Marcella Wilson</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____, or by _____, Student Embalmer No. _____, working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Sheldon Collier

Licensed Embalmer No. 338

P. O. Address St. Ann

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.