

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 1 1960

-60-001977

DED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 264 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Oklahoma b. COUNTY Muskogee		
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		Length of stay in lb 19 days	c. CITY OR TOWN Muskogee		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Research Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 2345 Manila St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Earl Middle T. Last Wheeler			4. DATE OF DEATH Month January Day 14 Year 1960		
5. SEX male	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-25-1897	9. AGE (last birthday) 62	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant Self employed		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Huntsville, Ark.		12. CITIZEN OF WHAT COUNTRY U. S. A.
13a. FATHER'S NAME Daniel Boone Wheeler		13b. MOTHER'S MAIDEN NAME Lillian Spurgeon		14. NAME OF HUSBAND OR WIFE Anna F. Wheeler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ---	17. INFORMANT Mr. Berle Wheeler Address Kansas City, Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) brain tumor- glioblastoma multiforme (malignant) left occipito-temporal					INTERVAL BETWEEN ONSET AND DEATH 2-3 mos.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)				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 checked="" type="checkbox"/> NO <input 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 12-26-59 to 1-14-60 and last saw her/him alive on 1-14-60 Death occurred at 10:20P. m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Daniel F. Roburn MD</i> (Degree or title)			22b. ADDRESS 411 Nichols Rd. K. C. Mo.		22c. DATE SIGNED 1-15-60
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 1-15-60	23c. NAME OF CEMETERY OR CREMATORY Rose Lawn		23d. LOCATION (City, town, or county) (State) Muskogee, Okla.	
24. FUNERAL DIRECTOR D. W. Newcomer's Sons ADDRESS 1331 Brush Creek		25. DATE RECD. BY LOCAL REG. 1-16-60	26. REGISTRAR'S SIGNATURE <i>Neva Marshall</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF DONALD F. COBURN

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 Chester K Brown

Licensed Embalmer No. 483

P. O. Address KPM

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.