

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-031413

FILED VS SEP 6 1960

Registration District No. 231 Primary Registration District No. 5808 Registrar's No. 42

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Montgomery	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bear Creek		Length of stay in lb 75 days	c. CITY OR TOWN High Hill Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jonesburg Nursing Home		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Clara Middle Bell Last Wheeler			4. DATE OF DEATH Month August Day 14 Year 1960		
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-17-1887	9. AGE (last birthday) 72	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Americus Missouri	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Enbrium Wheeler		13b. MOTHER'S MAIDEN NAME Elizabeth Davidson		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 492-36-4602	17. INFORMANT Steve Smith Address High Hill, Missouri		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: Adenocarcinoma of Uterus with Metastasis		INTERVAL BETWEEN ONSET AND DEATH 4 1/2 yrs.
IMMEDIATE CAUSE (a) Affecting Both Breasts, left Amputated		
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 (a) Cardio-vascular-renal syndrome, Arteriosclerosis		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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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 **May 26, 1956** to **Aug. 14, 1960** last saw her ^{him} alive on **Aug. 14, 1960**
Death occurred at **10:10** **p.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) C. H. Thompson DO	22b. ADDRESS New Florence, Mo.	22c. DATE SIGNED 8/16/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug. 16, 1960	23c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cemetery
23d. LOCATION (City, town, or county) (State) High Hill Missouri		

24. FUNERAL DIRECTOR Schlanker Funeral Home	25. DATE RECD. BY LOCAL REG. Aug 15-1960	26. REGISTRAR'S SIGNATURE Laura B. Callaway
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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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *E. B. [Signature]*

Licensed Embalmer No. 4136

P. O. Address *Montgomery*

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.