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| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Missouri</u> | | c. CITY OR TOWN <u>St. Louis</u> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis City Hosp. # 1</u> | | d. STREET ADDRESS (If outside, give location) <u>930 ALLEN</u> | |

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| 3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>Wheeler</u> Last <u>Wheeler</u> | | | 4. DATE OF DEATH Month <u>12</u> Day <u>10</u> Year <u>60</u> | | | |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>white</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 8-1892</u> | 9. AGE (last birthday) <u>78</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>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>ownhome</u> | | 11. BIRTHPLACE (City and state or country) <u>Farmington Mo</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u> |
| 13a. FATHER'S NAME <u>Thomas Davis</u> | | 13b. MOTHER'S MAIDEN NAME <u>Lucy Jane Treasex</u> | | 14. NAME OF HUSBAND OR WIFE <u>Milton Wheeler</u> | | |
| 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 <u>Milton Wheeler</u> Address <u>930 Allen St. Louis Mo</u> | | |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH <u>IMMED.</u> <u>MANY</u> <u>YEARS</u> |
| IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> | | |
| DUE TO (b) <u>ARTERIOSCLEROSIS, GENERALIZED</u> | | |
| DUE TO (c) <u>4201</u> | | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Psychotic DEPRESSIVE REACTION</u> | | | 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 | | |
| 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.) | | | |

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|---|--|--|------------------------------|--------|-------|
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. | 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 11 16 60 to 12 10 60 and last saw ^{her}/_{him} alive on 12 10 60
Death occurred at 7:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <u>Samuel S. Hellman MD</u> | 22b. ADDRESS <u>1515 Lafayette Avenue</u> | 22c. DATE SIGNED <u>12/10/60</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>12-13-60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>St Paul CEMETERY</u> | 23d. LOCATION (City, town, or county) (State) <u>Columbia, Ill.</u> |
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| 24. FUNERAL DIRECTOR <u>Josephine Schmidt</u> ADDRESS <u>Columbia, Illinois</u> | 25. DATE RECD. BY LOCAL REG. <u>DEC 12 1960</u> | 26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u> |
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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
or by me, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Josephine Schme
Licensed Embalmer No. 707

P. O. Address Columb

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