N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILED NOV 25 1940

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

36576
Do not use this space.

1. PLACE OF DEATH
(a) County Sullivan — Registration District No. 20 8592
(b) Township Duncan — Primary Registration District No. 6731 — Registered No.
(c) City Hager — (d) Street No. — St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mary Anna Wheeler
(a) Residence, No. Sullivan Co Mo Rural
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF William Wheeler

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 23, 1867

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	73	1	23	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pollock Mo.

FATHER
13. NAME Iain Grundstaff
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER
15. MAIDEN NAME Mary Purcon
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Wilbur Jasper Wheeler

18. BURIAL, CREMATION, OR REMOVAL
PLACE New Gum DATE 10-20 1940

19. FUNERAL DIRECTOR (NAME) Rogers & Son
(ADDRESS) Milan, Mo

20. FILED Nov 6 1940 Cleo Hagan Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 18 1940

22. I HEREBY CERTIFY, That I attended deceased from October 10, 1940, to October 18, 1940
I last saw h.e alive on October 11, 1940 Death is said to have occurred on the date stated above, at 7:30 P. m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Gangrene right foot	Sept 13 1940
Other contributory causes of importance: Tumor of gall bladder	1939

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) J. R. McClure, M. D.
(Address) Browning Mo.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 11-41-2098
Date Filed NOV 11 1940

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 .....

Registered Apprentice No....., working under my personal supervision.

Signed Russell C Hopper

Licensed Embalmer No. 3782

P. O. Address Milan Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 2B
2-21-40
I X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36576

Registration District No. 852 Primary Registration District No. 6121 Registrar's No.

1. PLACE OF DEATH:
(a) County Sullivan
(b) City or town Bucyrus
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Mary ann Wheeler
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 73 | Months 1 | Days 25 | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 18
year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Gangrene of rt foot.

Due to Arteriosclerosis

Due to

Other conditions Tumor of gall bladder
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature J. R. McArtor (M. D. or other)
Address Browning Mo Date signed