23731-a

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

Do not use this space.
23731-a

1. PLACE OF DEATH
County: Barry
Township: Flat Creek
City: (No. ..... St. ..... Ward)
Registration District No. 29
Primary Registration District No. 5038
File No.
Registered No. 77

2. FULL NAME: Mamie Pearl Wheeler
(a) Residence. No. ..... St., ... Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY AND YEAR): Aug. 16 1884
7. AGE: Years 44 | Months 11 | Days 8 | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY): Barry County

PARENTS
10. NAME OF FATHER: B. B. Nelley
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY): Barry County
12. MAIDEN NAME OF MOTHER: Babb
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY): Tennessee

14. INFORMANT: W. B. Wheeler
(Address): Cassville, Mo.
15. FILED: Sept 1 1929 Mrs H. R. Williams Dpt. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 7-24 1929
17. I HEREBY CERTIFY, That I attended deceased from Sept 28, 1928, to July 28 1929, that I last saw her alive on July 24 1929, and that death occurred, on the date stated above, at ..... m.
THE CAUSE OF DEATH* WAS AS FOLLOWS: Tuberculosis of Lungs.
23A
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY)
(duration) ..... yrs. ..... mos. ..... ds.
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? ..... DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Thos. H. Salyer, M. D.
July 27 1929 (Address) Cassville, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Granth
DATE OF BURIAL: 7-25 1929
20. UNDERTAKER: W. D. Koon
ADDRESS: Cassville Mo

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.

THIS IS A PERMANENT RECORD