

RECORDED OCT 10 1939

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

32311
Do not use this space.

1. PLACE OF DEATH *2*
(a) County *Douglas* Registration District No. *957*
(b) Township *Richland* Primary Registration District No. *5396*
(c) City *Iron Bridge, Mo.* (If 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 *3* yrs. *0* mos. *0* ds. (If of foreign birth? yrs. mos. ds.) How long in U. S., if of foreign birth?

2. PRINT FULL NAME *34*
(a) Residence, No. *300 Absolute B. Wheat* St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *ma* 4. COLOR OR RACE *whit* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *widowed*
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Martha J. Wheat*
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Oct 2 - 1869*
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *69 10 16*
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Farmer*
9. Industry or business in which work was done, as saw mill, bank, etc. *Farmer*
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) *Buckhart, Mo*
13. NAME *Jas. Wheat*
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *0*
15. MAIDEN NAME *Elizabeth Doherty*
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *0*
17. INFORMANT (ADDRESS) *J. Wheat Iron Bridge*
18. BURIAL, CREMATION, OR REMOVAL PLACE *Resident Home* DATE *8-19-39*
19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Wagon*
20. FILED *Sept. 30, 1939 Faye Thornton* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *8-18-39*
22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.
I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at *12:00 P.M.*
The principal cause of death and related causes of importance were as follows:
Carcinoma of Stomach
Date of onset _____
Other contributory causes of importance: *46*
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? *No*
If so, specify _____
(Signed) *Dr. Marvin Gentry*, M. D.
(Address) *awa. mo.*

Dr. Marvin Gentry

K. 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.

RECEIVED

District Health Officer No. 6,

District File Number 1039-2005

Date Filed OCT 6 1939

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.....

Licensed Embalmer No.....

P. O. Address.....

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