

Registration District No. _____

Primary Registration District No. 4408

Registrar's No. 9

MAR 7 - 1940

1. PLACE OF DEATH:

(a) County Pike
(b) City or town Bowling Green
(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) 20
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Laura Ann Wheeler 11.60

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife J. P. Wheeler 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec-17-1859
(Month) (Day) (Year)

8. AGE: Years 80 Months 1 Days 13 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Jewel M. Weatherford

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

14. Maiden name Mary B. Stanford

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

16. (a) Informant's own signature Mrs. Ollie Austin

(b) Address Bowling Green, Mo

17. (a) Spencersburg, Mo (b) Date thereof 2-2-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Spencersburg, Mo

18. (a) Signature of funeral director Spencer B. [unclear]

(b) Address Bowling Green Mo

19. (a) 2-11-40 (b) [unclear] (c) [unclear]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pike
(c) City or town Bowling Green
(If outside city or town limits, write "RURAL")
(d) Street No. 220 7th St
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 28
year 1940 hour 5 minute 40 P. M.

21. I hereby certify that I attended the deceased from Jan 25
_____, 1940, to Jan 28, 1940
that I last saw her alive on Jan 28, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Hyperstatic Pneumonia
Myocardial Infarction
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) A 2A

Major findings: Of operations _____
Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature [unclear] (M. D. or other) MD
Address Bowling Green Mo Date signed 2/1/40

Duration 1 day
1 week
PHYSICIAN
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A RE-ENTRY
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.

Rev. 5-17-39
U.S. GOVERNMENT PRINTING OFFICE

RECEIVED

District Health Officer No. 10

District File Number 3-40-479

Date Filed MAR 5 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, by

 , Registered Apprentice No.
working under my personal supervision.

Signed

Grace Paulshead

Licensed Embalmer No. 2204

P. O. Address

Bowling Green Mo

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 7765-

Registration District No. 684

Primary Registration District No. 4408

Registrar's No. 9

1. PLACE OF DEATH:

(a) County Pike
(b) City or town Bowling Green
(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 _____
In this community _____ (Specify whether years, months or days)

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

Laura Ann Wheeler

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 28
year _____ hour _____ minute _____ M.

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex 7 Color or race w

6. (a) Single, widowed, married, divorced wid
6. (c) Age of husband, or wife, if alive _____ year

6. (b) Name of husband or wife _____

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

8. AGE: Years Months Days If less than one day
80 1 13 _____ h _____ min.

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.
Immediate cause of death _____

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

Duration
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? _____

While at work? _____ (Specify type of place) _____
Means of injury _____

23. Signature J. H. Mathew (M. D. or other) _____
Address Bowling Green Date was

MOTHER FATHER

12. Name _____
13. Birthplace No Record (City, town, or county) _____ (State or foreign country)
14. Maiden name Don't know
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

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

18. (a) Signature of funeral director _____
(b) Address _____
19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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

SUPPLEMENTAL

