

No. 2
1-13-40
-17-39
X23159

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1865
Registrar's No. 95

Registration District No. 85

Primary Registration District No. 1001

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 624 N. 6th.
(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 30 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Buchanan

(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")

(d) Street No. 624 N. 6th.
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME CATHERINE E. WHEELAND

3. (b) If veteran, name war none 3. (c) Social Security No. none

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

6. (b) Name of husband or wife August Wheeland 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 23rd. 1854
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>86</u>	<u>8</u>	<u>28</u>	_____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business Home

12. Name Thomas Lankford

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

14. Maiden name Catherine McClanahan

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

16. (a) Informant Chas. W. Stafford

(b) Address 2511 Mitchell St. Joseph, Mo.

17. (a) Removal (b) Date thereof 1 - 23 - 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Platte City, Mo.

18. (a) Signature of funeral director FLEEMAN & SON, INC.

(b) Address St. Joseph, Mo.

19. (a) Jan. 23, 1941 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 21
year 1941 hour 7 minute 05 P. M.

21. I hereby certify that I attended the deceased from Jan 21, 1941
to Jan 21st 1941
that I last saw her alive on Jan 21st 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia

Due to _____
Due to _____

Other conditions Senile Dementia
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy none

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? _____

85
While at work? _____ (Specify type of place)
(c) Means of injury _____

23. Signature R.W. Tadlock (M. D. or other) [Signature]
Address King Hill Pldg. Date signed 4/1

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

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 Carl W. Hause

Licensed Embalmer No. 3906

P. O. Address St. Joseph, 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, fact should be so stated above.