17487

V. S. No. 2
DM—9-4-41
ev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 18 1942

Registration District No. 85

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 186

Primary Registration District No. 1001

Registrar's No. 530

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

11
1
7

1. PLACE OF DEATH:

(a) County Buchanan County

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

(c) Name of hospital or institution: State Hospital No. 2 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 22 yrs, 11 Mo, 1 Day (Specify whether)
In this community 22 yrs, 11 mo. plus
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Buchanan 11
1
7

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

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 2

If yes, name country

3. (a) PRINT FULL NAME William A. Wheeler

3. (b) If veteran, name war

3. (c) Social Security No. none

4. Sex Male 2

5. Color or race Colored

6. (a) Single, widowed, married, divorced 9 Unknown

6. (b) Name of husband or wife Unk.

6. (c) Age of husband or wife if alive Unk. years

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

8. AGE: Years	Months	Days	If less than one day
Unknown.			hr. min.

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

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace " (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace " (City, town, or county) 9 (State or foreign country)

16. (a) Informant No information
(b) Address

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-25-42 (Month) (Day) (Year)
(c) Place: burial or cremation State Hospital No 2

18. (a) Signature of funeral director Grewes Funeral Home
(b) Address 806 S. 17th

19. (a) 5-25-42 (Date received local registrar) (b) Rose Herzog (Registrar's signature)

1203

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 22
year 1942 hour 6 minute 10 A.M.

21. I hereby certify that I attended the deceased from May 1, 1942, to May 2/2, 1942
that I last saw h in alive on May 2/2, 1942
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulmonary Embolism	
Due to Gangrene of leg and amputation	
Due to 98:2	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations Gangrene of lower right leg.
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 Tom Carmichael (M. D. or other)
Address St Joseph Mo. Date signed 5/22/42

(Licensed Embalmer's Statement on Reverse Side)

NOT EMBALMED

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, fact should be so stated above.