DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 4 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 16115

Registration District No. 799 Primary Registration District No. 1002 Registrar's No. 2204

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wheatley Provident Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days (Specify whether
In this community 30 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missiuri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 620 Charlotte
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Earl Wheeler
3. (b) If veteran, name war None
3. (c) Social Security No. none
4. Sex Male
5. Color or race Col
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Maggie Wheeler
6. (c) Age of husband or wife if alive 50 years
7. Birth date of deceased 11 (Month) 8 (Day) 1883 (Year)
8. AGE: Years 61 Months 4 Days 8 If less than one day hr. — min.
9. Birthplace (City, town, or county) Oklahoma (State or foreign country)
10. Usual occupation Laborer
11. Industry or business Street Cleaning Dept.
FATHER
12. Name Unknown
13. Birthplace (City, town, or county) Unknown (State or foreign country)
MOTHER
14. Maiden name Unknown
15. Birthplace (City, town, or county) Unknown (State or foreign country)
16. (a) Informant Maggie Wheeler
(b) Address 620 Charlotte
17. (a) burial (Burial, cremation, or removal) (b) Date thereof 5/16/45 (Month) (Day) (Year)
(c) Place: burial or cremation Lincoln Cemetery
18. (a) Signature of funeral director Watkins Bros.
(b) Address 1729 Lydia
19. (a) 5-21-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 13th year 1945 hour 9:25 minute A. M.
21. I hereby certify that I attended the deceased from 5-5-45 5/13, 1945 to ____, 19__; that I last saw h____ alive on ____, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute Cardiac Dilatation	1 hr
Due to Aortic & mitral Regurgitation	9 Month
Due to	
Other conditions none (Include pregnancy within 3 months of death)	
Major findings: Of operations —	
Of autopsy none	

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 M. Tillman (M. D. or other) M.D.
Address 1618 Lydia Date signed 5/14/45

(Licensed Embalmer's Statement on Reverse Side)

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.....I Jerome Manlove

Licensed Embalmer No.....3994

P. O. Address.....2503 Highland

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1204

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

1. PLACE OF DEATH:

(a) County: Jackson

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

(c) Name of hospital or institution: Wheatley Hosp.
(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

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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Earl Wheeler

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex

5. Color or race

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

6. (b) Name of husband or wife

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

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

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

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-16-45 (Month) (Day) (Year)

(c) Place: burial or cremation Seeds

18. (a) Signature of funeral director

(b) Address

19. (a) 5-21-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Day 13 year 1945 hour minute M.

21. I hereby certify that I attended the deceased from to , 19; that I last saw him alive on , 19; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

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)

(b) 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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

16115