

1871

FILED JAN 21 1946

State File No. _____
 Registrar's No. **5324**

Registration District No. 199 Primary Registration District No. 1002

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
 (c) Name of hospital or institution: K.C. General Hosp. No. 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 20 ds
 In this community 35 years
 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City
 (d) Street No. 3730 Olive
 (e) Citizen of foreign country? 0
 If yes, name country _____

3. (a) PRINT FULL NAME Allen Wheeler
 (b) If veteran, name war Unknown
 (c) Social Security No. Unknown

MEDICAL CERTIFICATION
 23. DATE OF DEATH: Month Dec. 20th
 year 1945 5 day 45 A.
 hour minute M.

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Widower
 6. (b) Name of husband or wife Cala E. Wheeler
 6. (c) Age of husband or wife if alive Dead years
 7. Birth date of deceased Unknown
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 11-30-45 19, to 12-20-45 19,
 that I last saw him alive on 12-20-45 19,
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
About 75 hr. min.

Immediate cause of death Arteriosclerotic heart disease-Bronchopneumonia
 Duration _____

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

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

10. Usual occupation Retired several years
 Industry or business Unknown

Major findings: 93 d
 Of operations _____

MOTHER FATHER {
 12. Name Unknown
 13. Birthplace Unknown
 14. Maiden name Unknown
 15. Birthplace Unknown

PHYSICIAN
 Underline the cause to which death should be charged statistically.
 Of autopsy None

16. (a) Informant Mrs. Roy Holtzclaw
 (b) Address 4053 Central K.C. Mo.
 17. (a) Burial (b) Date thereof 12/24/45
 (Burial, cremation, or removal) (Month) (Day) (Year)

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? _____
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(c) Place: burial or cremation Mt. Moriah Cemetery
 18. (a) Signature of funeral director Melody-McGilley-Eylar
 (b) Address 1800 Linwood Blvd. K.C. Mo.
 19. (a) 12-24-45 (b) Geraldine Holmes
 (Date received local registrar) (Registrar's signature)

23. Signature Clark W. Sedberry
 Address Med. Dir. K.C. Gen. Hosp. K.C. Mo.
 Date signed _____

100428 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. H. H. ...

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 *W. E. ...*

Licensed Embalmer No. *40.63*

P. O. Address *Kansas City, 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.