

S. No. 2  
DM-5-43  
v. 5-17-39  
P I X36671

#57196  
DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

19040  
State File No. \_\_\_\_\_  
4413  
Registrar's No. \_\_\_\_\_

FILED MAY 27 1946  
318  
Registration District No. \_\_\_\_\_

Primary Registration District No. 1003

17918  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis City Hospital-Max C. Starkloff  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County St. Louis  
(c) City or town St. Louis Berkeley City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 6824 Fairchild Ave.  
Memorial (If rural, give location) N R I.  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) \_\_\_\_\_  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JAMES A. WHEAT  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_  
4. Sex male  race white 5. Color or race \_\_\_\_\_  
6. (b) Name of husband or wife Cariline Wheat 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Sept. 17 1855  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month May day 15th  
year 1946 hour 10:35 minute P M.  
21. I hereby certify that I attended the deceased from 4/27/46  
\_\_\_\_\_, 19\_\_\_\_, to 5/15/46, 19\_\_\_\_;  
that I last saw him alive on 5/15/46, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
90 7 28 hr. min.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_  
Bronchopneumonia  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Acute Psychosis  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy not done  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

9. Birthplace Berkley Springs W. Va.  
(City, town, or county) (State or foreign country)  
10. Usual occupation Farmer  
11. Industry or business Retired  
12. Name Joseph Wheat  
13. Birthplace Bath Va.  
(City, town, or county) (State or foreign country)  
14. Maiden name Miranda Grove  
15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)  
16. (a) Informant Mrs. Claire Kelly  
(b) Address 6824 Fairchild Ave.  
17. (a) Burial (b) Date thereof 5-18-46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Calvary Cemetery  
18. (a) Signature of funeral director Drehmann-Harral  
(b) Address 1905 Union Blvd.  
19. (a) MAY 16 1946 J. F. Bredenk  
(Data received from local registrar) (Registrar's signature)

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) \_\_\_\_\_ (Specify means of injury)  
23. Signature R. L. Stubbelford (M. D. or \_\_\_\_\_)  
Address 1420 Grather Date signed 5-18-46

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**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..... *Albert R. Thompson*

Licensed Embalmer No. *4237*

P. O. Address *St. Louis*

**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.**