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5-17-39  
X36671

20784

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 156

Primary Registration District No. 2001

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Jasper

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

(c) Name of hospital or institution: St. John's Hospital  
(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 Missouri (b) County Jasper <sup>49</sup>

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

(d) Street No. 2015 Fern Ave.  
(If rural, give location)

(e) Citizen of foreign country?          (Yes or No)  
If yes, name country         

3. (a) PRINT FULL NAME Myrtle Freeman Wheeler

3. (b) If veteran, name war         

3. (c) Social Security No.         

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife         

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

7. Birth date of deceased April 7, 1885  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 19 year 1946 hour 6:50 minute 0 M.

21. I hereby certify that I attended the deceased from 5-11-46, 1946, to 5-19-46, 1946, that I last saw her alive on 6:40 p.m. 5-19-46 and that death occurred on the date and hour stated above.

Immediate cause of death Leukemia - carcinoma

Duration 5-11-46

8. AGE: Years 61 Months 1 Days 12 If less than one day          hr.          min.

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

10. Usual occupation         

11. Industry or business at home

MOTHER FATHER { 12. Name Jim Madison Freeman

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

14. Maiden name Myrtle Ellen Freeman

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

16. (a) Informant John R. Ruffin

(b) Address Jasper, Mo.

17. (a) Burial (b) Date thereof May 21, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Hope Cemetery

18. (a) Signature of funeral director W. H. Atchill

(b) Address 1111 N. 2nd St. Jasper, Mo.

19. (a) 5/20/46 (b) Ed. D. Jones  
(Date received local registrar) (Registrar's signature)

Due to         

Due to         

Other conditions           
(Include pregnancy within 3 months of death)

Major findings:         

1. Of operations         

Of autopsy         

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?         

1. While at work?          (Specify type of place) (e) Means of injury         

23. Signature Ed. D. Jones (M. D. or other)         

Address Jasper, Mo. Date signed 5-20-46

**ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED**

PHYSICIAN           
Underline the cause to which death should be charged statistically.

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

46-5-475

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 myself

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Clayton M. Johnston

Licensed Embalmer No. 430x

P. O. Address Webb 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. July  
Registrar's No. \_\_\_\_\_

Registration District No. 156 Primary Registration District No. 2001

1. PLACE OF DEATH:  
(a) County Jasper  
(b) City or town Joplin  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(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

3. (a) PRINT FULL NAME Myrtle F. Wheeler  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color of race W  
6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_  
7. Birth date of deceased April 18 1880  
(Month) (Day) (Year)

8. AGE: Years 61 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Mo  
(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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month \_\_\_\_\_ Year 1949 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death myophosaroma  
not detected in cervical nodes.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 W. E. Stern (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

**SUPPLEMENTARY**

ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED

PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

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