

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

FILED NOV 19 1946

State File No.

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1254

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2610 1/2 St. Joseph Avenue
(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) 74 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan //
(c) City or town St. Joseph /
(If outside city or town limits, write "RURAL")
(d) Street No. 2610 1/2 St. Joseph Ave. 7
(If rural, give location) No 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

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

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 5. Color of race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Cecile Wheeler 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased May 17 1870
(Month) (Day) (Year)

8. AGE: Years 76 Months 5 Days 18 If less than one day hr. _____ min. _____

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

10. Usual occupation Retired Salesman

11. Industry or business _____

12. Name W. Rolland Wheeler

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

14. Maiden name Mary Rayburn

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

16. (a) Informant Mrs. Cecile Wheeler

(b) Address St. Joseph, Mo.

17. (a) Burial (b) Date thereof 11/8/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director Beale & Bowman

(b) Address St. Joseph, Mo.

19. (a) Nov. 12, 1946 (b) A. Westbush
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 5
year 1946 hour 11 minute 30 AM.

21. I hereby certify that I attended the deceased from TRV-15T
19 46 to Nov 4 1946
that I last saw him alive on Nov 4 1946
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Cardiac failure

Due to Hemorrhage

Due to Carcinoma

of esophagus & trachea

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

Major findings: _____

Of operations _____

Of autopsy 47A

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)

(e) Means of injury 2

23. Signature J. H. Hedgcock (M. D. or other) OB
Address St. Joseph, Mo. Date signed 11-7-46

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING INK—MAKE A PERMANENT RECORD

