

FILED APR 23 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16164

Registration District No. 347

Primary Registration District No. 6168

Registrar's No.

1. PLACE OF DEATH

(a) County Stone Elroy Mo.
 (b) City or town
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community About 1 1/2 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Grauer Wheeler

3. (b) If veteran, name war. mo

3. (c) Social Security No. 500-16-3085

4. Sex m o 5. Color or race wh
 6. (a) Single, widowed, married, divorced. Divorced

6. (b) Name of husband or wife
 6. (c) Age of husband or wife if alive. 4 years

7. Birth date of deceased Jan 21 1888
 (Month) (Day) (Year)

8. AGE: Years 59 Months 1 Days 12 If less than one day hr. min.

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

10. Usual occupation Farming

11. Industry or business

12. Name Rhenken Wheeler 9

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

14. Maiden name Katha Rhodes 9

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

16. (a) Informant Dorothy Wheeler

(b) Address Stone Elroy Mo

17. (a) Burial (b) Date thereof Mar 6 - 47 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. Aerial Spex

18. (a) Signature of funeral director. Everett G. Cheatham

(b) Address Stone Elroy Mo

19. (a) March 19-47 (b) Lena Murray Dep. (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Stone Mo
 (c) City or town Lincoln 1046 (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 March day 3 year 1947 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from Feb 11, 47 to Death 19 47

that I last saw him alive on March 3, 19 47 and that death occurred on the date and hour stated above.

Immediate cause of death. Influenza

Duration

Due to

Due to

Other conditions Myocarditis, Chronic (Include pregnancy within 3 months of death)

Major findings: Of operations 93A

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:

(c) 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) Means of injury

23. Signature Fred J. Nemmel (M. D. or other) MO

Address Stone Elroy Mo Date signed 3-15-47

RECEIVED

District Health Officer No. 6;

District File Number 447-499

Date Filed APR 22 1947

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 Everett J. Cheatham

Licensed Embalmer No. 3870

P. O. Address Galena Mo

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

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

Registration District No. 347

Primary Registration District No. 6169

1. PLACE OF DEATH:

(a) County Stone

(b) City or town Elsey
(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 about 1 1/2 yrs. years, months or days)

3. (a) PRINT FULL NAME Graves Wheeler

3. (b) If veteran, name war _____

3. (c) Social Security No. 500-10-3089

4. Sex m 5. Color or race w

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: Jan 21 1915
(Month) (Day) (Year)

8. AGE: Years 59 Months _____ Days _____ (if less than one day)
hr. _____ min _____

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

10. Usual occupation farmer

11. Industry or business _____

12. Name Rheuben Wheeler

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

14. Maiden name Fatha Rhodes

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

16. (a) Informant Dorothy Wheeler

(b) Address Elsey, Missouri

17. (a) Burial (b) Date thereof Mar. 6-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Quail Spur,

18. (a) Signature of funeral director Everette J. Chestnut

(b) Address Quail, MO

19. (a) May 9 1947 (b) Myrtle Broussard
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stone

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

(d) Street No. Lincoln Township
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 3
year 1947 hour _____ minute 30 P. M.

21. I hereby certify that I attended the deceased from Feb-11-1947
to March 3, 19____;
that I last saw him alive on March 3, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Influenza

Duration _____

Due to myocarditis
Chronic

Due to _____

Other conditions _____
(Include pregnancy within 8 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) _____

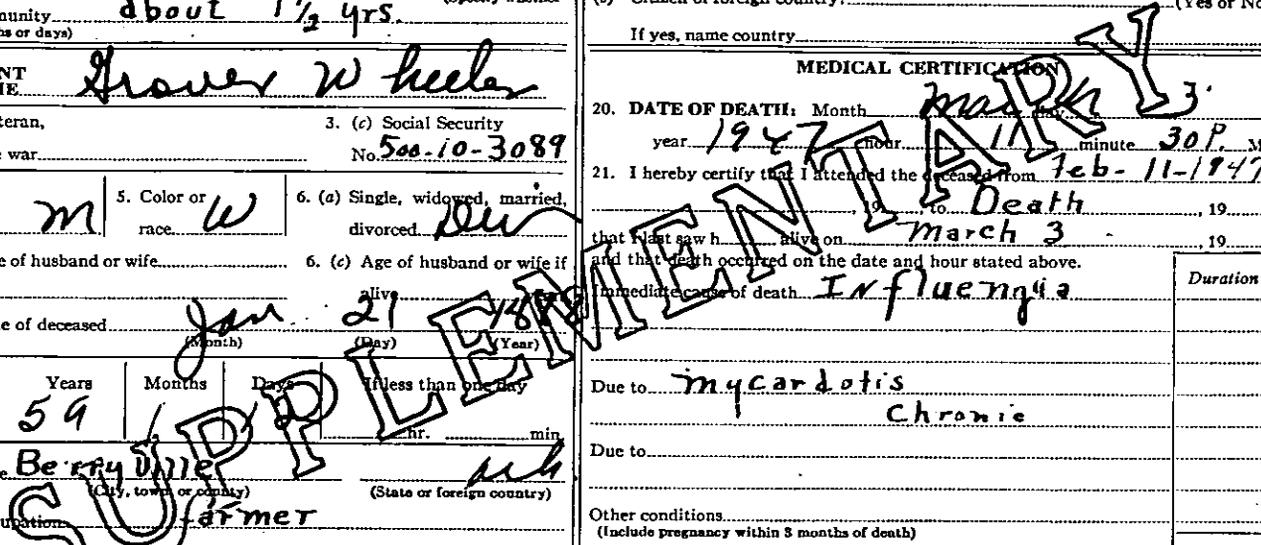
(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(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 _____

23. Signature Fred F. Wommack (M. D. or other) M.D.
Address Crane, Missouri Date signed 3-15-47



MOTHER FATHER

STATE & TERRITORY RECORD

16164.