

No. 300  
-10-47  
-17-39  
3906

Registration District No. 78

Primary Registration District No. 3015

**1. PLACE OF DEATH:**

(a) County Clinton

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

(c) Name of hospital or institution:  
615 N. Chestnut 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 6 years  
years, months or days

3. (a) PRINT FULL NAME Hannie Elizabeth Wheeler

3. (b) If veteran, name war

3. (c) Social Security No. None

4. Sex F 5. Age or race W

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

6. (b) Name of husband or wife John Hill Wheeler

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

7. Birth date of deceased Feb 25 1861  
(Month) (Day) (Year)

8. AGE: Years 87 Months 8 Days 2  
If less than one day hr. min.

9. Birthplace No record Ind. 1  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Wm. Brock

13. Birthplace Rockingham Co. Va 1  
(City, town, or county) (State or foreign country)

14. Maiden name Catherine Zuber

15. Birthplace Va. 1  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Joe Moyer

(b) Address Cameron

17. (a) Burial (b) Date thereof 10-29-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bethany country Slep. Md

18. (a) Signature of funeral director Robert Samuel Home

(b) Address Cameron

19. (a) Oct. 28, 48 (b) Wm. Fred W. Moyer  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Clinton<sup>25</sup>

(c) City or town CAMERON 1  
(If outside city or town limits, write "RURAL")

(d) Street No. 615 N CHESTNUT 0  
(If rural, give location)

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

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Oct day 26 27  
year 1948, 11 hour 10 minute PM

21. I hereby certify that I attended the deceased from 8-5-48  
\_\_\_\_\_, 19\_\_\_\_, to 10-27-48 19\_\_\_\_

that I last saw her alive on 9-10, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction  
Duration \_\_\_\_\_

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

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

Other conditions Fracture femur, Rt. Hip  
(Include pregnancy within 3 months of death)

Major findings: heart

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?  
(Specify type of place) (e) Means of injury

23. Signature Edmund M.D. (M.D. or other)  
Address Cameron, Mo Date signed 10-29-48

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

**DISTRICT HEALTH OFFICE  
Cameron, Mo.**

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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. no  
Registrar's No. 37

Registration District No. 75 Primary Registration District No. 3015

1. PLACE OF DEATH:  
(a) County Clinton  
(b) City or town Cameron  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days)

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

4. Sex F 5. Color or 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 Feb 25  
(Month) (Day) (Year)

8. AGE: Years 87 Months \_\_\_\_\_ Days \_\_\_\_\_ (Unless than one day)  
hr. \_\_\_\_\_ min \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Ind

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 \_\_\_\_\_

20. DATE OF DEATH: Month Dec 7  
year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

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) Fraction Rt. Hip on fall at home  
(b) Date of occurrence 10-30-48  
(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 W. James M.D. (M. D. or other) \_\_\_\_\_  
Address Cameron, Ind Date signed 11-7-48

SUPPLEMENTARY

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

S-32378