

FILED MAY 20 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
318

1003

State File No. 17799  
4257 Registrar's No.

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>St Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Missouri</u>		c. LENGTH OF STAY (In this place) <u>15 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kinloch</u>		9/10 6	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Barnes Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>33 Jefferson Ave.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u>		b. (Middle) <u>A.</u>		c. (Last) <u>Wheeler</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 7 1949</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>1/2/1883</u>	
9. AGE (In years last birthday) <u>66</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Tungen, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Carrie Wheeler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>496-142121</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Carrie Wheeler 33 Jeff. Kinloch</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Thrombosis of cerebral artery</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause. (a) stating the underlying cause last.</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u> <u>Bronchopneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) _____ (STATE) <u>Mo.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>333X</u>			
22. I hereby certify that I attended the deceased from <u>Apr 22</u> , 19 <u>49</u> , to <u>May 7</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>May 7</u> , 19 <u>49</u> , and that death occurred at <u>11:00P.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>J. B. Hasater</u>				23b. ADDRESS <u>Barnes Hospital</u>		23c. DATE SIGNED <u>5/8/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>5/12/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Washington Park Cem</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>	
DATE REC'D BY LOCAL REG. <u>MAY 12 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Hasater</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. T. Nash</u>		ADDRESS <u>384 Pers</u>	

*NR*

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

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

*C. J. Noe*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

*3847 Jago*

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.