

FILED DEC 5 1949
Springfield, Mo.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36951**

BIRTH MO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **200** Registrar's No. **1030**

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

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield	
c. LENGTH OF STAY (in this place) 15 Yrs.		d. STREET ADDRESS (If rural, give location) 2043 N. National	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2043 N. National		e. STREET ADDRESS 2043 N. National	

3. NAME OF DECEASED (Type or Print) Rosa Viola Wheeler			4. DATE OF DEATH (Month) (Day) (Year) Nov. 25, 1949		
a. (First)		b. (Middle)		c. (Last)	

5. SEX F M	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 2, 1874	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months 6 Days 23	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Sweet Home, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A

13a. FATHER'S NAME Leroy Harry		13b. MOTHER'S MAIDEN NAME Mary Smith		14. NAME OF HUSBAND OR WIFE James Edward Wheeler	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Marl Golding 1613 E. Belmont			
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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, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 5 Min.	
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage			
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension + arteriosclerosis DUE TO (c) Chronic Bronchectasis			
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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **3 Aug. 1949**, to **25 Nov. 1949**, that I last saw the deceased alive on **25 Nov. 1949**, and that death occurred at **11 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Samuel E. Knapp M.D.	23b. ADDRESS 1630 N. Jefferson	23c. DATE SIGNED 26 Nov 49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11-28, 1949	24c. NAME OF CEMETERY OR CREMATORY Pleasant View	24d. LOCATION (City, town, or county) (State) near Elkland, Mo.
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DATE REC'D BY LOCAL REG. 11-28-49	REGISTRAR'S SIGNATURE W.E. Handley	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. L. Dunn Springfield, 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *H. M. Cass*

Licensed Embalmer No. 2727

P. O. Address *Springfield 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.