

FILED JUL 17 1950

STANDARD CERTIFICATE OF DEATH

State File No. **23348**

BIRTH NO. **39170** REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **615**

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| 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, 1396 | |
| c. LENGTH OF STAY (in this place) 5 hours | | d. STREET ADDRESS (If rural, give location) 1410 E. McDaniel | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Springfield Baptist Hospital | | | |

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|-------------------------------------|----------------------------|------------------------|--------------------------|--------------------------------------|
| 3. NAME OF DECEASED (Type or Print) | a. (First) S Sharon | b. (Middle) Kay | c. (Last) Wheeler | 4. DATE OF DEATH July 7, 1950 |
|-------------------------------------|----------------------------|------------------------|--------------------------|--------------------------------------|

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| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant | 8. DATE OF BIRTH July 7, 1950 | 9. AGE (In years last birthday) 0 | IF UNDER 1 YEAR 0 Months 0 Days | IF UNDER 4 HRS. 5 Min. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant | 10b. KIND OF BUSINESS OR INDUSTRY Infant | 11. BIRTHPLACE (State or foreign country) Springfield, Mo. | 12. CITIZEN OF WHAT COUNTRY? USA |
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| 13a. FATHER'S NAME Clarence Wheeler | 13b. MOTHER'S MAIDEN NAME Edna Mullen | 14. NAME OF HUSBAND OR WIFE Infant |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | 16. SOCIAL SECURITY NO. no | 17. INFORMANT'S SIGNATURE OR NAME Clarence Wheeler | ADDRESS Springfield, |
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|---|--|--|-----|----------------------------------|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | MO. | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Subtentorial hemorrhage 5 hrs | | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Birth injury 5 hrs DUE TO (c) Cephalo-Thoracic disproportion | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None | | | | 7:00 |

| | | |
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| 19a. DATE OF OPERATION None | 19b. MAJOR FINDINGS OF OPERATION None | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) Birth injury | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY TOWN, OR TOWNSHIP) (COUNTY) (STATE) Springfield Greene Mo |
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|--|---|---|
| 21d. TIME OF INJURY 7-7-7:50 PM | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 21f. HOW DID INJURY OCCUR? Birth injury. |
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22. I hereby certify that I attended the deceased from **July 7, 1950**, to **July 7, 1950**, that I last saw the deceased alive on **July 7, 1950**, and that death occurred at **10:30 PM**, from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) R. O. Conrad, M.D. | 23b. ADDRESS Springfield, Mo. | 23c. DATE SIGNED 7-8-50 |
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|---|-------------------------------|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE July 8, 1950 | 24c. NAME OF CEMETERY OR CREMATORY Eastlawn | 24d. LOCATION (City, town, or county) (State) Springfield, Missouri |
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| DATE REC'D BY LOCAL REG. 7-11-50 | REGISTRAR'S SIGNATURE W E Handley M.D. | 25. FUNERAL DIRECTOR'S SIGNATURE Norman Schupp | ADDRESS 7: Home Springfield, Mo |
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10.48
396

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 Rob Embalmed

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.