

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27190

State File No. ....

4000  
FILED JUL 23 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 547 Registrar's No. 1901

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Illinois</u> b. COUNTY <u>Alexander</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Richmond Heights MO</u>		c. CITY OR TOWN <u>Cairo</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Marys Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>2818 Park Avenue., 8120</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Martha</u> b. (Middle) <u>Wheeler</u> c. (Last) <u>Gannon</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 9 1953</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug 18 1898</u>
9. AGE (In years last birthday) <u>54</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 2 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Cairo, Illinois</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Charles W. Wheeler</u>	
13b. MOTHER'S MAIDEN NAME <u>Agnes Glynn</u>		14. NAME OF HUSBAND OR WIFE <u>John T. Gannon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No Nil</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Phillip Barkett, Charleston, Missouri</u>		ADDRESS <u>  </u>	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congestive Heart Failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs</u> ANTECEDENT CAUSES DUE TO (b) <u>Intra auricular Septal Defect Congenital</u> DUE TO (c) <u>Plus Myocard. Vasc Disease?</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>2/43X</u>	
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)		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 <u>7-6</u> , 19 <u>53</u> , to <u>7-9</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>7-8</u> , 19 <u>53</u> , and that death occurred at <u>2:30A</u> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Ralph Kusella M.D.</u>		23b. ADDRESS <u>3720 Washington</u>	
23c. DATE SIGNED <u>7/9/53</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
24b. DATE <u>7-9-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>City</u>	
24d. LOCATION (City, town, or county) (State) <u>Cairo, Illinois</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Albert H. Hoppe</u>	
DATE REC'D BY LOCAL REG. <u>7-9-53</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Domb, M.D.</u>	
ADDRESS <u>  </u>		ADDRESS <u>4700 Washington Blvd</u>	

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

AUG 4 1953

---

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.....  
Signature of Student Embalmer

Signed.....  
*Fred J. Farmer*

Licensed Embalmer No.....  
*4788*

P. O. Address.....  
*St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.