

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45665

State File No. _____

FILED JAN 19 1954

BIRTH NO. _____ REG. DIST. NO. 355 PRIMARY REG. DIST. NO. 6204 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Texas</u> <u>1079</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Texas</u>		
b. CITY OR TOWN <u>Summersville Mo</u>		c. LENGTH OF STAY (in this place) <u>25 yrs</u>	c. CITY OR TOWN <u>Summersville, Mo</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>None</u>			e. STREET ADDRESS (If rural, give location) <u>Rural - etc <u>1070</u></u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>Alice</u> b. (Middle) <u>Elizabeth</u> c. (Last) <u>Wheeler</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 24th 1953</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov 22- 1876</u>		9. AGE (In years last birthday) <u>77</u> # UNDER 1 YEAR Months _____ Days _____ # UNDER 1 HR. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Illinois</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Frank Caldwell</u>		13b. MOTHER'S MAIDEN NAME <u>Not Known</u>	
14. NAME OF HUSBAND OR WIFE <u>C.W. Wheeler</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT'S SIGNATURE OR NAME <u>C.W. Wheeler</u>		ADDRESS <u>Summersville, Mo</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, asthma, etc. It means the disease, injury, or complication which caused death.	
19. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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>4201</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? _____	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>2 PM</u> m., from the causes and on the date stated above.					
23a. SIGNATURE <u>James L. Gentry (Cooper)</u> (Degree or title) _____			23b. ADDRESS <u>Calool, Mo.</u>		23c. DATE SIGNED <u>12-28-53</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Dec 27 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Arroll Cem</u>		24d. LOCATION (City, town, or county) (State) <u>Arroll Mo.</u>
DATE REC'D BY LOCAL REG. <u>1-18-54</u>		REGISTRAR'S SIGNATURE <u>Anna Roberts</u> <u>433-0</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Duncan Funeral Home Mtn View, Mo</u>	

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..

Student.....
Signature of Student Embalmer

Signed..... *John G. Hansen*

Licensed Embalmer No. *27*

P. O. Address..... *17th Street*

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.