

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16633

State File No. _____

No. 300
10.48

FILED MAY 24 1954

BIRTH NO. _____		REG. DIST. NO. <u>209</u>		PRIMARY REG. DIST. NO. <u>3043</u>		Registrar's No. <u>149</u>	
1. PLACE OF DEATH a. COUNTY <u>Marion</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Hannibal</u>		c. LENGTH OF STAY (In this place) <u>5/8/54</u>		c. CITY OR TOWN <u>Hannibal</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>Levering Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>623 1/2 Broadway</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Frankie</u> b. (Middle) <u>Wheeler</u> c. (Last) <u>Wheeler</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>May 14, 1954</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>January 15, 1881</u>		9. AGE (In years last birthday) <u>73</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>29</u>	IF UNDER 1 HR. 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>XX</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Clarksville Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		
13a. FATHER'S NAME <u>Louis Price</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Tucker Price</u>		14. NAME OF HUSBAND OR WIFE <u>Charles Earl Wheeler (deceased)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>XX</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Ray Bird Albany New York</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.	MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Infarction</u>					<u>15 min.</u>	
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Fracture Neck Left</u>						
	DUE TO (c) <u>Humerus</u>					<u>6 days</u>	
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>E9000 21</u>						
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Hannibal</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Hannibal Marion MO</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u> </u> m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell down steps at Home.</u>			
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>11:00 AM.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Jess Landa M.D.</u>				23b. ADDRESS <u>707 Broadway</u>		23c. DATE SIGNED <u>5/18/54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>May 18, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Grand View</u>		24d. LOCATION (City, town, or county) (State) <u>Hannibal Missouri</u>		
DATE REC'D BY LOCAL REG. <u>5/20/54</u>	REGISTRAR'S SIGNATURE <u>Paul M. Landa by M. J. Fisher</u>			GENERAL DIRECTOR'S SIGNATURE <u>M. C. Clark</u>		ADDRESS <u>Hannibal Missouri</u>	

(Licensed Embalmer's Statement on Reverse Side)

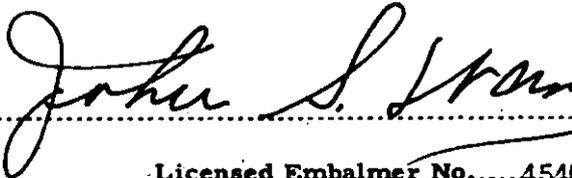
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED MAY 21 1954
MARION CO. HEALTH DEPT.
DATE FILED MAY 21 1954

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.....


Licensed Embalmer No.....454

P. O. Address..Hannibal.Miss.

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.