

FILED MAY 29 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17316

State File No. _____

 BIRTH NO. 32291-56 REG. DIST. NO. 278 PRIMARY REG. DIST. NO. 3054 Registrar's No. 78

1. PLACE OF DEATH a. COUNTY <u>Pike</u>			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Pike</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Louisiana</u>		c. LENGTH OF STAY (in this place) <u>10 hrs.</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Clarksville</u> <u>0820</u>		d. STREET ADDRESS (If rural, give location) <u>0</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Pike Co. Hospital</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Infant (Heeler)</u> b. (Middle) <u>Wheeler</u> c. (Last) <u>Wheeler</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 21 1956</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Infant</u>	8. DATE OF BIRTH <u>May 20, 1956</u>	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days
				<u>10</u>	IF UNDER 28 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	11. BIRTHPLACE (State or foreign country) <u>Louisiana Mo. 0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13a. FATHER'S NAME <u>Amos Conway</u>		13b. MOTHER'S MAIDEN NAME <u>Mrs. Wheeler</u>		14. NAME OF HUSBAND OR WIFE <u>_____</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. <u>X</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Amos Conway, Clarksville 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.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Anoxia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) <u>Compression of Umbilical Cord</u> DUE TO (c) <u>Delayed Preech Delivery</u> II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>5 hours.</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION. <u>7610</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>5/20, 1956</u> , to <u>5/21, 1956</u> , that I last saw the deceased alive on <u>5/20, 1956</u> , and that death occurred at <u>5:00 a.m.</u> , from the causes and on the date stated above.					
22a. SIGNATURE (Degree or title) <u>Dr. Barber M.D.</u>			23b. ADDRESS <u>Clarksville Mo.</u>		23c. DATE SIGNED <u>5/21/56</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>May 21, 1956</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>	24d. LOCATION (City, town, or county) (State) <u>Clarksville Mo.</u>		
DATE REC'D BY LOCAL REG. <u>May 22, 1956</u>	REGISTRAR'S SIGNATURE <u>Bernice Collier</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Harold L. Barrett Clarksville Mo.</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

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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.....

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.