

Health,  
Welfare  
Public  
Service

FILED JUL 31 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26687

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6803**

300  
1-56

Doctor, coroner, or other person must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1.</b>		Length of stay in lb <b>25</b>	d. STREET ADDRESS (If outside, give location) <b>5 No. 9th. St.</b>
3. NAME OF DECEASED (Type or print) <b>OLIVER</b> <sup>First</sup> <b>WHEELER</b> <sup>Last</sup>		4. DATE OF DEATH <b>JULY 13, 1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 7 1884</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pinsetter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bowling Alley</b>	11. BIRTHPLACE (City and state or country) <b>Clinton Indiana</b>
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>+94-07-7124A</b>	17. INFORMANT Address <b>City Hosp. Records 1515 Lafayette</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Insufficiency of basilar artery.</b> DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour Month, Day; Year a. m. p. m.	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <b>7/11/57</b> to <b>7/13/57</b> and last saw <sup>her</sup> <del>him</del> alive on <b>7/13/57</b> Death occurred at <b>7:05 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Robert J. Owen, M.D.</b>		22b. ADDRESS <b>1515 LAFAYETTE AVE.</b>	22c. DATE SIGNED <b>7/15/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>July 19, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>	23d. LOCATION (City, town, or county) (State) <b>Normandy Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Wm. J. Morrell 3710 N. Grand Blvd</b>		25. DATE RECD. BY LOCAL REG. <b>JUL 22 57</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith</b>

(Licensed Embalmer's Statement on Reverse Side)

8501

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 J. Haine*  
Licensed Embalmer No. 410

P. O. Address *St Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.