

FILED OCT 14 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30839

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 374

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Mississippi</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Charleston</u> <u>Mo</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>University of Mo Medical Center</u> Length of stay in lb <u>30 days</u>		d. STREET ADDRESS (If outside, give location) <u>407 E Cypress</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bertha Brewer Wheatley</u>			4. DATE OF DEATH Month Day Year <u>Oct 7 57</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 11, 1891</u>
9. AGE (In years last birthday) <u>66</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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>Cook</u>	11. BIRTHPLACE (City and state or country) <u>Sparta, Illinois</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13a. FATHER'S NAME <u>Robert Welsh</u>	
13b. MOTHER'S MAIDEN NAME <u>Mary</u>		14. NAME OF HUSBAND OR WIFE <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>498-98-7542</u>	17. INFORMANT <u>Hospital Chart</u> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage into brain</u> Interval between onset and death <u>2 days</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Acute granulocytic leukemia</u> Interval between onset and death <u>3 months</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>2041</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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.		20d. INJURY OCCURRED WHILE AT <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 <u>9-6-57</u> to <u>10-7-57</u> and last saw her alive on <u>10-7-57</u> Death occurred at <u>2:45 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Diane Burkett M.D.</u>		22b. ADDRESS <u>University of Missouri</u>	
22c. DATE SIGNED <u>10-7-57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10/9/1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Charleston, Mo.</u>
24. FUNERAL DIRECTOR <u>Lynnan Sprinkle</u> ADDRESS <u>Columbia</u>		25. DATE RECD. BY LOCAL REG. <u>Oct 7 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R.E. Palomare</u>

MEDICAL CERTIFICATION  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

1957 OCT 17

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 *Lyman Sprinkle* .....

Licensed Embalmer No. *4013* .....  
P. O. Address *Columbia, Mo.* .....

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.