. Health,
& Welfare
S. Public
th Service

S. 300
v. 1-56

Doctor, coroner, etc. 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

FILED OCT 21 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 38329

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9282

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Homer G. Phillips — Length of stay in 1b 0 — 27

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY /
c. CITY OR TOWN St. Louis 2309 0 — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS 2809 Cass (If outside, give location) — Reside on Farm Yes ☐ No ☐ — 20

3. NAME OF DECEASED (Type or print) First Adele Middle Last Wheeler
4. DATE OF DEATH Month 10 Day 1 Year 57
5. SEX Female 3
6. COLOR OR RACE Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 2
8. DATE OF BIRTH 9-17-1903
9. AGE (In years last birthday) 54 — 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) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (City and state or country) Tenn. 1
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charie Wheeler
14. MOTHER'S MAIDEN NAME Ellen Chapell
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Corine Walls Address 4205 W. CooK

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH Undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hyoertension
DUE TO (c) 443x
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertensive Cardiovascular Disease 2
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 9-10-57, to 10-1-57 and last saw her alive on 10-1-57
Death occurred at 9:40 p. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Marvin Rosecan, M.D. 0
22b. ADDRESS 2601 N. Whittier St.
22c. DATE SIGNED 10-4-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 10-7-57
23c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery
23d. LOCATION (City, town or county) St. Louis Co. Mo (State)

24. FUNERAL DIRECTOR Russell Undertaking Co. ADDRESS 2732 Pine
25. DATE RECD. BY LOCAL REG. OCT 5 57
26. REGISTRAR'S SIGNATURE J Earl Smith - MD

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed James A. Carter

Licensed Embalmer No. 46

P. O. Address ..... Lom

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