

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-012479
STATE FILE NUMBER

FILED APR 9 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

3652

300
1-57
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hospital #1		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 2807 Wisconsin
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Rebecca Middle D. Last Wheat			4. DATE OF DEATH Month March Day 30 Year 1958		
------------------------------------------------------------------------------------------------	--	--	-----------------------------------------------------------------------	--	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-22-1889	9. AGE (in years In ¹⁰⁰ birthday) 68	IF UNDER 1 YEAR Months 08 Days	IF UNDER 24 HRS. Hours 00 Min.
----------------------	-------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------	--------------------------------------------------------	------------------------------------------	------------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Davisville, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--------------------------------------------------------------------------------------------------------------	---------------------------------------------------	-------------------------------------------------------------------	--------------------------------------------

13a. FATHER'S NAME D.C. Wilkinson	13b. MOTHER'S MAIDEN NAME Ida Smith	14. NAME OF HUSBAND OR WIFE Charles Wheat
------------------------------------------	--------------------------------------------	--------------------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT Address Charles Wheat, 2807 Wisconsin
---------------------------------------------------------------------------------------------------------------------	-------------------------	------------------------------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction - suspected Atherosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	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)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) 2
-----------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------

20c. TIME OF INJURY Hour p.m. Month, Day, Year	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 Mar. 26, 1958 to Mar. 30, 1958 and last saw her alive on Mar. 30, 1958 Death occurred at 4:30 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Carson M. Bernstein M.D.	22b. ADDRESS 1515 Lafayette	22c. DATE SIGNED 3/30/58
------------------------------------------------------------------	------------------------------------	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4-3-1958	23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
----------------------------------------------------------	---------------------------	----------------------------------------------------------------	---------------------------------------------------------------------------------

24. FUNERAL DIRECTOR ADDRESS McLAUGHLIN'S, 2301 Lafayette Ave.	25. DATE RECD. BY LOCAL REG. MAR 31 '58	26. REGISTRAR'S SIGNATURE Charles Smith MD m.B.
-----------------------------------------------------------------------	------------------------------------------------	------------------------------------------------------------------

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *H. G. Ferris*

CS Licensed Embalmer No. *3384*
P. O. Address *H. Ferris*

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.