

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-018929
State File No.

No. 300
10-48

FILED MAY 27 1958

BIRTH NO. _____		REG. DIST. NO. <u>184</u>		PRIMARY REG. DIST. NO. <u>3038</u>		Registrar's No. <u>58</u>	
1. PLACE OF DEATH a. COUNTY <u>Linn</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admittance) a. STATE <u>Mo</u> b. COUNTY <u>Linn</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Brookfield</u>		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <u>Brookfield</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>103 E Park</u>				e. STREET ADDRESS (If rural, give location) <u>103 E Park St.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Lesta</u> b. (Middle) <u>Pearl</u> c. (Last) <u>Wheeler</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>May 14 1958</u>				
5. SEX <u>♀</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed 2</u>		8. DATE OF BIRTH <u>July 30, 1881</u>	
9. AGE (In years last birthday) <u>76</u>		IF UNDER 1 YEAR Months <u>9</u> Days <u>14</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
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		11. BIRTHPLACE (City and State or Foreign Country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William H. Frost</u>			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE <u>Robert Lee Wheeler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Ralph J. Wheeler Brookfield</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>Acute congestive heart failure.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>D.O.A.</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive cardiac-malacia, 6 years.</u> DUE TO (c) <u>Generalized arteriosclerosis.</u>					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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) (Min.)		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>12-20</u> , 19 <u>55</u> , to <u>5-14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5-13</u> , 19 <u>58</u> , and that death occurred at <u>4:20</u> p.m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>D.W. Bohannon M.D.</u>				23b. ADDRESS <u>Brookfield, Mo.</u>		23c. DATE SIGNED <u>5/15/58</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>5/17/58</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Rosehill Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Brookfield Mo</u>	
DATE REC'D BY LOCAL REG. <u>5-19-58</u>		REGISTRAR'S SIGNATURE <u>Walter Brown</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Boudens Brookfield, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

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AUG 14 1958

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 *James B. Mc Clelland*

Licensed Embalmer No. *423*

P. O. Address *Brookfield*

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.