

Health,
& Welfare
Public
Service
821
S. 300
v. 1-57

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-026525
STATE FILE NUMBER

FILED JUL 16 1958 Registration District No. 278 Primary Registration District No. 3034 Registrar's No. 107

1. PLACE OF DEATH a. COUNTY PIKE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY PIKE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN LOUISIANA Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN EOLIA 0820 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION PIKE CO HOSPITAL Length of stay in 1b		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ANNIE BELL WHEELER			4. DATE OF DEATH Month Day Year JULY 7 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 APRIL 25 1875
9. AGE (In years last birthday) 83		10. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) HOUSE WIFE	11. BIRTHPLACE (City and state or country) ROCK FORT ILLINOIS
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME JAMES PATRICK	13b. MOTHER'S MAIDEN NAME MARY J SHEPHERD HORTZ
14. NAME OF HUSBAND OR WIFE ARTHUR WHEELER		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.
17. INFORMANT ARTHUR WHEELER		Address EOLIA MO	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aneurysm, Upper Aorta			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Hypertensive cardiovascular disease with pulmonary congestion.			
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.) -----	
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. Attended the deceased from 1948 to 7-7-58 and last saw her ^{her} _{him} alive on 7-7-58 Death occurred at 4:35 Pm on the date stated above; and to the best of my knowledge, from the causes stated.			
Signature of Physician (Degree or title) Bernice Collier M.D.		22b. ADDRESS Louisiana, Missouri	22c. DATE SIGNED 7/8/58
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE JULY 9-58	23c. NAME OF CEMETERY OR CREMATORY EOLIA CEMETARY	23d. LOCATION (City, town, or county) (State) EOLIA MO
24. FUNERAL DIRECTOR GEO M. COLLIER		ADDRESS LOUISIANA MO	25. DATE RECD. BY LOCAL REG. July 14-58
26. REGISTRAR'S SIGNATURE Bernice Collier			

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

(Licensed Embalmer's Statement on Reverse Side)

JAN 21 1959

MS
JUL 15 1960

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

Licensed Embalmer No.....

P. O. Address.....

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.