ealth,
Welfare
ublic
ervice

300
-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-009113
STATE FILE NUMBER

FILED MAR 23 1959

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 292

1. PLACE OF DEATH a. COUNTY Greene	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN Strafford 0390 — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Mercy Hosp — Length of stay in 1b	d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Middle Last: Baker Henry Wheeler

4. DATE OF DEATH Month Day Year: Mar. 17, 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Mar. 2, 1882

9. AGE (In years last birthday): 77 — 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): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own farm

11. BIRTHPLACE (City and state or country): Unknown

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: Wm. B. Wheeler

13b. MOTHER'S MAIDEN NAME: Unknown

14. NAME OF HUSBAND OR WIFE: Amanda A. Wheeler

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.: None

17. INFORMANT Address: Mrs. Rita Stewart, Springfield, Mo.

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) Carcinoma, Undifferentiated, Primary Unknown — INTERVAL BETWEEN ONSET AND DEATH: 8 mos

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): Cerebral Arteriosclerosis 1942

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 Sep 2, 58, to Mar 17, 59 and last saw her/him alive on Mar 16, 59

Death occurred at 5:15 P. M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): R D Callaway, Jr M.D.

22b. ADDRESS: Springfield, Mo

22c. DATE SIGNED: Mar 19, 59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 3-19-59

23c. NAME OF CEMETERY OR CREMATORY: Walnut Grove

23d. LOCATION (City, town, or county) (State): Smallett, Missouri

24. FUNERAL DIRECTOR ADDRESS: Clinkingbeard Funeral Home, Ava, Mo.

25. DATE RECD. BY LOCAL REG.: 3-20-59

26. REGISTRAR'S SIGNATURE: Effie G. Melton

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 Lewis G Scharpf

Licensed Embalmer No. 3802

P. O. Address Springfield

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.