

FILED MAR 27 1959

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011503

Registration District No. Primary Registration District No.
STATE FILE NUMBER 2717
Registrar's No.

300
-57

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1. PLACE OF DEATH a. COUNTY St. Louis Mo		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		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS 4455 Kennerly	
3. NAME OF DECEASED (Type or print) First Middle Last Harold William Wheeler		4. DATE OF DEATH Month Day Year 3 13 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 August 1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
13a. FATHER'S NAME William Wheeler		13b. MOTHER'S MAIDEN NAME Larua Bruno	14. NAME OF HUSBAND OR WIFE Mrs Roxetta Wheeler
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) N		16. SOCIAL SECURITY NO. 486-22-8393	17. INFORMANT Address Mrs Roxetta Wheeler 4455 Kennerly Ave
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 of Colon with Metastasis			INTERVAL BETWEEN ONSET AND DEATH undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			153.8
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Bronchopneumonia - Bronchial Asthma			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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. I attended the deceased from 2-13-59 to 3-13-59 and last saw ^{xx} him alive on 3-13-59 Death occurred at 3:05 A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Henschell Hamilton (Degree or title) M.D.		22b. ADDRESS 2601 Whittier Street	
22c. DATE SIGNED 3-13-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3/18/59	
23c. NAME OF CEMETERY OR CREMATORY Washington Park		23d. LOCATION (City, town, or county) (State) St. Louis County Mo	
24. FUNERAL DIRECTOR Herman J. Smith ADDRESS 4247/w Labadie Ave		25. DATE RECD. BY LOCAL REG. MAR 17 '59	
26. REGISTRAR'S SIGNATURE Mrs Rod Smith, M.D.			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *W. Claude Gudon*

Licensed Embalmer No. *3481*
P. O. Address *1575 11th St*

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.