

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023613

FILED JUN 22 1959 Registration District No. 317 Primary Registration District No. 541 STATE FILE NUMBER Registrar's No. 1613

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WELLESTON CLAYTON</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>WELLSTON 4301</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CO. HOSPITAL</u> Length of stay in 1b <u>12 DAYS</u>		d. STREET ADDRESS (If outside, give location) <u>6424 HOBART</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Emanuel Wheeler</u>			4. DATE OF DEATH Month Day Year <u>6-13-59</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 11, 1884</u>
9. AGE (In years last birthday) <u>74</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>	11. BIRTHPLACE (City and state or country) <u>BLAIR, PA.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED 10 YRS</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
13a. FATHER'S NAME <u>WILLIAM WHEELER</u>		13b. MOTHER'S MAIDEN NAME <u>SARA RHODES</u>	14. NAME OF HUSBAND OR WIFE <u>ELLA WHEELER</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>ELLA WHEELER 6424 HOBART</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>331XF</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Acute Sepsis/pneumonia; Fracture (IT) left femur</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) <u>Pt fell while walking &amp; injured left hip</u>		
20c. TIME OF INJURY Hour a.m. p.m. <u>5:00/59</u>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>480</u>		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>ST. LOUIS</u>	COUNTY STATE <u>MO.</u>
21. I attended the deceased from <u>6-1-1959</u> to <u>6-13-1959</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>6-13-1959</u> Death occurred at <u>5:35</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Verant J. Trudnich MD</u>		22b. ADDRESS <u>601 So. Brentwood, Clayton</u>	22c. DATE SIGNED <u>6/15/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>JUNE 16, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS COUNTY MO.</u>
24. FUNERAL DIRECTOR ADDRESS <u>SHEPARD FUNERAL HOME 1167 HAMILTON</u>		25. DATE RECD. BY LOCAL REG. <u>6-15-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>

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

*J. Wm Binkley*

Licensed Embalmer No. *3653*

P. O. Address *St. Louis, Mo.*

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.