

**STATE DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED MS MAR 30 1960

**60-013493**  
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 830

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirkwood</b>		Length of stay in 1b <b>15 Yrs.</b>	c. CITY OR TOWN <b>Kirkwood</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Bethesda-Dilworth Home</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1601 E. Big Bend</b>		
3. NAME OF DECEASED (Type or print) First <b>MAUDE</b> Middle <b>LEE</b> Last <b>WHEATLEY</b>			4. DATE OF DEATH Month <b>Mar.</b> Day <b>9</b> Year <b>1960</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7-26-78</b>	9. AGE (last birthday) <b>81</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>Union City, Tenn.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>John Roland</b>		13b. MOTHER'S MAIDEN NAME <b>----- Bynum</b>		14. NAME OF HUSBAND OR WIFE <b>Allen Wheatley</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Harrol Wheatley, 425 Clifside Ct.</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Virus Pneumonia</b>					INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic vascular disease etc.</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). <b>Dysrhythmias etc.</b>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
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 _____ a.m. _____ p.m.	Month, Day, Year _____						
20d. INJURY OCCURRED WHILE AT WORK <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 <b>Mar. 1<sup>st</sup> 1960</b> to <b>Mar 9 1960</b> and last saw her <b>him</b> alive on <b>Mar 9 1960</b> Death occurred at <b>2:10 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>O. Deabaugh M.D.</b>			22b. ADDRESS <b>Webster Groves Mo</b>		22c. DATE SIGNED <b>3/10/60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>3-11-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>City Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Union City, Tenn.</b>			
24. FUNERAL DIRECTOR <b>Parker-Aldrich, Webster Groves</b>			ADDRESS	25. DATE RECD. BY LOCAL REG. <b>3-10-60</b>	26. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Leslie Welch

Licensed Embalmer No. 439

P. O. Address Webster St

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to do so 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.