WHITE PERMANENT, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

8295

File No. 1149

Registered No. 1149

1. PLACE OF DEATH
County Jackson
Township Kaw
City Kansas City (No. 743 W. 35th St. Ward)
Registration District No. 399
Primary Registration District No. 10031

2. FULL NAME Lana Elizabeth Wheeland
(a) Residence. No. 743 W 35th St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: Wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Unknown

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dec. 2, 1858

7. AGE: Years 68 | Months 3 | Days 15 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ia.

PARENTS
10. NAME OF FATHER: Wm. Munds
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Va.
12. MAIDEN NAME OF MOTHER: Emmaly Rafler
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ohio

14. INFORMANT: Wilma Hazel Wheeland
(Address) 743 W. 35th St.

15. FILED 3/17, 1927 M. M. Crowe Asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR): Mar 17 1927

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19.....
that I last saw h..... alive on ..... 19....., and that death occurred, on the date stated above, at 6:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
93A
93C
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Aortic Insufficiency
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
(Signed) Chas. S. Nelson M. D
3-17, 1927 (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Mt. Washington
DATE OF BURIAL: Mch 19 1927

20. UNDERTAKER: D. H. Newcomer's Sons
ADDRESS: K. C. Mo.