

FILED JUN 15 1940 991

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 4646

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Johns Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____
years, months or days

8. (a) PRINT FULL NAME Richard Wyland 453

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex MALE 5. Color or race White 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased MAY 26 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day hr. 4 min.

9. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Frank Wyland
18. Birthplace St. Louis Mo
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Clark
15. Birthplace St. Louis Mo
(City, town, or county) (State or foreign country)

16. (a) Informant FRANK Wyland

(b) Address 4167 MAFFITT St.

17. (a) _____ (b) Date thereof 5-27-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director St. Louis Funeral Home

(b) Address 2205 St. Louis ave

19. (a) MAY 27 1940 (b) J.F. Brueck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4167 Maffitt
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 26
year 1940 hour 12 midnite M.

21. I hereby certify that I attended the deceased from May 25th 7:36 P.M. 1940, to 12 midnite May 26 1940 that I last saw h. alive on 12 midnite May 26 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity - possible atelectases

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature E. J. McCall (M. D. or other) _____

Address 307 Studid Date signed 5-27-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

....., Registered Apprentice No.
working under my personal supervision.

Signed.....

Licensed Embalmer No.

P. O. Address.....

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 this body is not embalmed, above space should be left blank.