

FILED FEB 11 1946

Registration District No. 199

Primary Registration District No. 1002

Registrar's No. 555

1. PLACE OF DEATH:

(a) County JACKSON
(b) City or town KANSAS CITY
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution RESEARCH HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 WEEK
(Specify whether years, months or days)
In this community 11 YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County JACKSON
(c) City or town KANSAS CITY
(If outside city or town limits, write "RURAL")
(d) Street No. 3538 HARRISON STREET
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME MRS MARJORIE WHEELER WIEGAND
3. (b) If veteran, name war NO No. none

4. DATE OF DEATH: Month FEB day 1 ST
year 1946 hour 3 minute 07 P M.

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife MR. KARL WIEGAND 6. (c) Age of husband or wife if alive 48 years
7. Birth date of deceased OCTOBER-25-1891
(Month) (Day) (Year)

2. I hereby certify that I attended the deceased from Jan 24 1946 to Feb 1 1946
that I last saw her alive on Feb 1 1946
and that death occurred on the date and hour stated above

8. AGE: Years 54 Months 3 Days 7 If less than one day hr. _____ min. _____

Immediate cause of death Acute Pulmonary Embolus Sudden
Due to Thrombophlebitis Pelvic, Iliac + femoral veins
Due to Previous small

9. Birthplace SLATER MISSOURI
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) Pulmonary emboli with infarction
Major findings: None present
Of operations None

10. Usual occupation AT HOME

11. Industry or business _____

12. Name JAMES CRAWFORD WHEELER

13. Birthplace SLATER MISSOURI
(City, town, or county) (State or foreign country)

14. Maiden name HOBIE PRICE

15. Birthplace YINKOWA MISSOURI
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. MARY R. O'CONNOR
(b) Address 3397 PASEO

17. (a) BURIAL (b) Date thereof FEB-4-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEMETERY

18. (a) Signature of funeral director J. H. Newcomer's Son
(b) Address 1401 BRUSH CREEK BLVD

19. (a) 2-2-46 (b) Steraline Holmes
(Date received local registrar) (Registrar's signature)

PHYSICIAN
Under the which death should be charged statistically.
Had thrombophlebitis following pelvic and iliac veins

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? _____

23. Signature Dr. Ferris (Name of physician)
Address 922 Lafayette Blvd (City or town) (County) (State)
Date Feb 2 1946

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 *A.C. Newcomer*

Licensed Embalmer No. *40430*

P. O. Address *A.C. 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 this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. *Ward*
Registrar's No. *555*

Registration District No. *149*

Primary Registration District No. *1002*

1. PLACE OF DEATH

(a) County *Jackson*
(b) City or town *Jackson City*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME *Marjorie Wiegand*

3. (b) If veteran, name war _____ 3. (c) Social Security No. *495-09-7065*

4. Sex _____ 5. Color or race _____ 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 (Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) *2-2-46* (b) *Heraldine Holmes*
(Date received local register) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year _____
hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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)

(b) 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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

