No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 9, 1947

Registration District No. 1

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3033

State File No. 31693

Registrar's No.

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Lebanon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wallace Memorial O
(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 Missouri (b) County Laclede 53
(c) City or town Lebanon Rural O
(If outside city or town limits, write "RURAL")
(d) Street No. Highway 66 near Lebanon O
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Harold C. Wieland
3. (b) If veteran, name war
3. (c) Social Security No. 554-12-6471

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Wanda Wieland
6. (c) Age of husband or wife if alive 27 years
7. Birth date of deceased Sept. (Month) 15 (Day) 1917 (Year)

8. AGE: Years 29 Months 11 Days 28 If less than one day ..... hr. ..... min.

9. Birthplace Grandforks N. Dakota (City, town, or county) (State or foreign country)
10. Usual occupation Auto Parts man
11. Industry or business
FATHER
12. Name Carl Wieland
13. Birthplace Unknown (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Augusta — — —
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant Mrs Wanda Wieland
(b) Address Lebanon Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-14-47 (Month) (Day) (Year)
(c) Place: burial or cremation Minot N. Dakota
18. (a) Signature of funeral director W. E. Holman
(b) Address Lebanon Mo.
19. (a) Oct. 4, 1947 (Date received local registrar) (b) Org. Frankeburger (Registrar's signature) 15

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 13
year 1947 hour 9 minute 30 P.M.

21. I hereby certify that I attended the deceased from 9-13-, 1947, to 9-13-, 1947; that I last saw him alive on 9-13-, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Diabetes Melitus	(?)
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations (6)	
Of autopsy	

PHYSICIAN
Underline the cause of 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)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature B. E. Howell (M. D. or other) MD
Address Lebanon Mo Date signed 9-15-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

Received 10/7/47

Laclede County Health Unit

File No. 9-47-161

Date Filed 10/8/47

AUG 11 1948

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 Dorsey M. Howe

Licensed Embalmer No. 4222

P. O. Address Lebanon 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.