

FILED AUG 15 1949

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 22820

BIRTH NO. _____		REG. DIST. NO. <u>57</u>		PRIMARY REG. DIST. NO. <u>5228</u>		Registrar's No. <u>116</u>			
1. PLACE OF DEATH a. COUNTY <u>Cass</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): a. STATE <u>Illinois</u> b. COUNTY <u>Edgar</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural</u>		c. LENGTH OF STAY (in this place) <u>2</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas Russell Marshall</u>		d. STREET ADDRESS (If rural, give location) <u>109 South Second</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Greystone Hill Township</u>									
3. NAME OF DECEASED (Type or Print) a. (First) <u>Frederick</u> b. (Middle) <u>August</u> c. (Last) <u>Wieland</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 4 1949</u>						
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>Aug 29-1960</u>			
9. AGE (In years) (last birthday) <u>88</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Sandusky, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>John Wieland</u>			13b. MOTHER'S MAIDEN NAME <u>Kathryn Ackerman</u>		14. NAME OF HUSBAND OR WIFE <u>Lara Helen Lutz</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT'S SIGNATURE OR NAME <u>John M Wieland</u> ADDRESS <u>Marshall Ill</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) * This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Senility</u>									
ANTECEDENT CAUSES				DUE TO (b) _____					
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (c) _____					
II. OTHER SIGNIFICANT CONDITIONS				<u>Chr. Hypertension</u>				<u>7-9-48</u>	
Conditions contributing to the death but not related to the disease or condition causing death.									
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____					
22. I hereby certify that I attended the deceased from <u>Aug 3, 1949</u> to <u>Aug 3, 1949</u> , that I last saw the deceased alive on <u>Aug 3, 1949</u> , and that death occurred at <u>12:30 p.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Name or title) <u>Chas Eaper M.D.</u>				23b. ADDRESS <u>Lee's Summit Mo</u>		23c. DATE SIGNED <u>8/5/49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Aug 5, 49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Clarksville, Ill.</u>		24d. LOCATION (City, town, or county) (State) <u>Marshall Ill.</u>			
DATE REC'D BY LOCAL REG. <u>Aug 6, 1949</u>		REGISTRAR'S SIGNATURE <u>Rama Jones</u>		51		25. FUNERAL DIRECTOR'S SIGNATURE <u>W B Langford</u> ADDRESS <u>Lee's Summit Mo</u>			

(Signed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

N. Bangsford

Signed _____
Student Embalmer

Licensed Embalmer No. _____

3833

P. O. Address _____

Leis Summit

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.