

FILED MAY 27 1950

STANDARD CERTIFICATE OF DEATH

18775

State File No. 4545

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Iowa b. COUNTY	
b. CITY OR TOWN St Louis Mo	c. LENGTH OF STAY (In this place) 25 days	c. CITY OR TOWN Mt Pleasant	8140
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital		d. STREET ADDRESS (If rural, give location) 407 Broadway 8	

3. NAME OF DECEASED (Type or Print) CLAY a. (First) b. (Middle) c. (Last) Wier			4. DATE OF DEATH (Month) (Day) (Year) 5-22-50				
5. SEX Male	6. COLOR OF RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 4-9-1899	9. AGE (In years last birthday) 51	# UNDER 1 YEAR Months	# UNDER 1 MIN. Hours	# UNDER 1 MIN. Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dealer		10b. KIND OF BUSINESS OR INDUSTRY Coal	11. BIRTHPLACE (State or foreign country) Mt Pleasant Iowa		12. CITIZEN OF WHAT COUNTRY? USA		

13a. FATHER'S NAME Ed Wier		13b. MOTHER'S MAIDEN NAME Tixie Montgomery Frances		14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Frances Wier Mt Pleasant Iowa		ADDRESS	

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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 10 days	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis, generalized			5 years	
		DUE TO (c) <i>J</i>				
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic heart disease			3 years	

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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? B31X	

22. I hereby certify that I attended the deceased from 4-28, 1950, to 5-22, 1950, that I last saw the deceased alive on 5-22, 1950, and that death occurred at 6:25A m., from the causes and on the date stated above.

23a. SIGNATURE F. Bradley		(Degree or title) M.D.		23b. ADDRESS BARNES HOSPITAL		23c. DATE SIGNED 5/22/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 5-22-1950		24c. NAME OF CEMETERY OR CREMATORY Mt Pleasant		24d. LOCATION (City, town, or county) (State) Iowa	
DATE RECD. BY LOCAL REG. 2 1950		REGISTRAR'S SIGNATURE J. B. Parater		25. FUNERAL DIRECTOR'S SIGNATURE R. K. Crane Mt Pleasant Iowa			

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

4545

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

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, fact should be so stated above.