

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

FILED JAN 17 1958

17406  
 STATE FILE NUMBER  
 6279

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

V. S. 300  
 Rev. 1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City Mo.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>368 Kansas City Mo.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St Marys Hosp.</b>		Length of stay in lb <b>59Yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>2535 Bales</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Mrs. Bertha</b> Middle <del>Wiegand</del> Last <b>Wiegand</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>31</b> Year <b>1957</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 24, 1878</b>	9. AGE (In years) <b>79</b> birthday	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Blair Neb.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13a. FATHER'S NAME <b>Paul Crowe</b>		13b. MOTHER'S MAIDEN NAME <b>Bertha Crowe</b>		14. NAME OF HUSBAND OR WIFE <b>John T. Wiegand</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Paul T. Wiegand Buffalo N.Y.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b>					INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Myocardial infarction</b>					<b>5 days</b>
DUE TO (c) <b>Generalized arteriosclerosis</b>					<b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>4201</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>Dec 23 - 57</b> to <b>Dec 31 - 57</b> and last saw <sup>her</sup> <del>him</del> alive on <b>Dec 31 - 57</b> Death occurred at <b>3:00</b> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>M. A. Cline M.D.</b>			22b. ADDRESS <b>1002 Arroyo Bldg</b>		22c. DATE SIGNED <b>1-2-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1-2-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>		23d. LOCATION (City, town, or County) (State) <b>Kansas City Mo.</b>
24. FUNERAL DIRECTOR <b>Thomas E. Quirk 4316 Troost</b>			25. DATE RECD. BY LOCAL REG. <b>1-3-58</b>		26. REGISTRAR'S SIGNATURE <b>Neve Marshall</b>

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

M. A. Cline  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION



**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.

Student .....  
Signature of Student Embalmer

Signed *Thomas C. Parish*

Licensed Embalmer No. 3775

P. O. Address 6033 K. @ m-

**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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.**

**If this body is not embalmed, fact should be so stated above.**