

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

OF PUBLIC HEALTH AND WELFARE

6340-60-046428
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1001 Registrar's No. _____

FILED VS JAN 11 1961

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>4 yrs.</u>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4529 Forest</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MR. ALBERT</u> Middle <u>D</u> Last <u>WIELAND</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>16,</u> Year <u>1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>2-9-1870</u>	9. AGE (last birthday) <u>90</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>		11. BIRTHPLACE (City and state or country) <u>Richmond, Iowa</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>David Wieland</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Bonart</u>		14. NAME OF HUSBAND OR WIFE <u>Margaret</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Hilda Wieland- 4529 Forest</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>advanced age & debility</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>arterio-sclerosis, advanced.</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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 _____ a.m. _____ p.m. Month, Day, Year _____							
20d. INJURY OCCURRED WHILE AT WORK <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 <u>March 1957</u> to <u>Dec 1960</u> and last saw her alive on <u>Dec 15, 1960</u> Death occurred at <u>6 am.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>R Paul Wright M.D.</u>				22b. ADDRESS <u>1324 Paul Bldg</u>		22c. DATE SIGNED <u>Dec 16 '60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>12-16-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>unknown</u>		23d. LOCATION (City, town, or county) (State) <u>Richmond, Iowa</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Mellody-McGilley-Eylar--1800 E. Linwood</u>			25. DATE RECD. BY LOCAL REG. <u>12-16-60</u>		26. REGISTRAR'S SIGNATURE <u>H. S. Dwyer</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Paul Wright

Dr. Paul
Jug. Bell

V12-130

7w. 12:30 +
1324

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Floyd R. Wick

Licensed Embalmer No. 5120

P. O. Address K.E. 9

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to
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.