

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-009227

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1311

STATE FILE NUMBER

AMENDED

FILED MAR 29 1961

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>	Length of stay in 1b <b>15 yrs.</b>	c. CITY OR TOWN <b>Kansas City</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Menorah Medical Center</b>		d. STREET ADDRESS (If outside, give location) <b>2246 Denver</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Lena</b> Middle <b>Weiland</b> Last <b>Weiland</b>	4. DATE OF DEATH Month <b>March</b> Day <b>11</b> , Year <b>1961</b>
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5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1/13/1905</b>	9. AGE (last birthday) <b>56</b>	IF UNDER 1 YEAR Months <b>56</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HR Hours <b>0</b> Min. <b>0</b>
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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>Clarinda, Iowa</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>Edward Hoefle</b>	13b. MOTHER'S MAIDEN NAME <b>Arzelda Hoskins</b>	14. NAME OF HUSBAND OR WIFE <b>Joseph Weiland</b>
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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.	17. INFORMANT Address <b>Joseph Weiland 2246 Denver K. C., Mo</b>
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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>Carcinoma of right breast with metastases</b> DUE TO (b) <b>metastases</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____
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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
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21. I attended the deceased from 3-7-61 to 3-11-61 and last saw her/him alive on 3-11-61  
Death occurred at 12:05pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Walter B. Credit</b> M.D.	22b. ADDRESS <b>4949 Rockhill Road, K.C., Mo.</b>	22c. DATE SIGNED <b>3-12-61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3/13/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Floral Hills Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Earp &amp; Sons 4707 Truman Rd. K.C., Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>3-13-61</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 SHOULD READ  
 BY AFFIDAVIT OF  
 Morton C. Credit 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

*James W. Taylor*

Licensed Embalmer No. 4672

P. O. Address K.C., 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.