

FILED JAN 16 1952

STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 2

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

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Schlyer	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirksville		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Queen City, Missouri	
c. LENGTH OF STAY (If this place) 8 days		d. STREET ADDRESS (If rural, give location) Box 62	
d. FULL NAME OF HOSPITAL OR INSTITUTION Kirksville Osteopathic Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Adolph	b. (Middle) Earl	c. (Last) Wieneke	4. DATE OF DEATH (Month) (Day) (Year) 1 3 1952
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 6-13-1898
9. AGE (In years last birthday) 53		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Section Foreman	11. BIRTHPLACE (State or foreign country) Iowa
10b. KIND OF BUSINESS OR INDUSTRY Railroad		12. CITIZEN OF WHAT COUNTRY? US	

13a. FATHER'S NAME Gustavison Adolph Wieneke	13b. MOTHER'S MAIDEN NAME Ida Brown	14. NAME OF HUSBAND OR WIFE Bessie Mae Haynes
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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) No	16. SOCIAL SECURITY NO. 702-05-6741	17. INFORMANT'S SIGNATURE OR NAME Bessie Wieneke	ADDRESS Queen City, Mo
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adenocarcinoma of Cecum		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) generalized metastases DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION 11/14/1951	19b. MAJOR FINDINGS OF OPERATION Adenocarcinoma of Cecum - inoperable	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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) 153X
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Nov. 7, 1951**, to **Jan. 3, 1952**, that I last saw the deceased alive on **Jan. 3, 1952**, and that death occurred at **5:40 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE OF REGISTRAR R. D. Prosser	(Degree or title) D.O.	23b. ADDRESS Kirksville Mo	23c. DATE SIGNED 1-3-52
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24a. BURIAL CREMATION, REMOVAL (Specify) Removal	24b. DATE 1-3-52	24c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery	24d. LOCATION (City, town, or county) (State) Blount, Iowa
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DATE REC'D BY LOCAL REG. 1-3-52	REGISTRAR'S SIGNATURE Wintersville Kate Lambert	25. FUNERAL DIRECTOR'S SIGNATURE W. W. Miller	ADDRESS Blount, Iowa
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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
Student Embalmer

Signed: *[Handwritten Signature]*

Licensed Embalmer No. 3554

P. O. Address Blairfield Town

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.