Photocopy: Original placed in restricted file due to personal information

REGISTRATION DISTRICT NO. 147 REGISTRAR'S NUMBER 144

1. DECEDENT'S NAME (First, Middle, Last): LYLE DEAN WELAND
2 SEX: M
3. DATE OF DEATH (Month, Day, Year): NOVEMBER 17, 1993
4 SOCIAL SECURITY NO:
5a AGE - Last Birthday (Years): 57
5b UNDER 1 YEAR: MONTHS / DAYS
5c. UNDER 1 DAY: HOURS / MINUTES
6. DATE OF BIRTH (Month, Day, Year): 3/24/1936
7 BIRTHPLACE (City and State or Foreign Country): ELMO, MISSOURI
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? ☒ Yes ☐ No ☐ Unk.
9a. PLACE OF DEATH (check only one; see instructions on other side) HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA OTHER: ☐ Nursing Home ☐ Residence ☐ Other (specify)
9b FACILITY NAME (If not institution, give street and number): ST. FRANCIS HOSPITAL
9c. CITY, TOWN, OR LOCATION OF DEATH: MARYVILLE
9d. COUNTY OF DEATH: NODAWAY
10. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify): MARRIED
11. SURVIVING SPOUSE'S NAME (If wife, give last maiden name): BARBARA BAILEY
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): ARMY 20 YRS, LATER CAFE & ANTIQUE SHOP
12b. KIND OF BUSINESS OR INDUSTRY:
13a RESIDENCE - STATE: MISSOURI
13b COUNTY: NODAWAY
13c. CITY, TOWN, OR LOCATION: ELMO
13d. ZIP CODE: 64445
13e. STREET AND NUMBER: RR 1
13f. INSIDE CITY LIMITS ☐ Yes ☒ No
13g. YEARS AT PRESENT ADDRESS ☐ Under 5 ☒ 5-9 ☐ 10-19 ☐ 20 or more
14 WAS DECEDENT OF HISPANIC ORIGIN (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☒ No ☐ Yes Specify:
15. RACE - American Indian, Black, White, etc. (Specify): W
16 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): College (1-4 or 5+): 3½
17. FATHER'S NAME (First, Middle, Last): LAWRENCE G. WELAND
18 MOTHER'S NAME (First, Middle, Maiden Surname): LAURA VERLIE ECKER
19a INFORMANT'S NAME (Type/Print): BARBARA WELAND
19b MAILING ADDRESS (Street and Number, City or Town, State, Zip Code):
20a. BURIAL, CREMATION, OTHER (Specify): BURIAL
20b DATE OF DISPOSITION (Month, Day, Year): 11/19/1993
20c. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): HIGH PRAIRIE
20d. LOCATION - City or Town, State: ELMO, MO
21. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH: [signature]
22a NAME AND ADDRESS OF FACILITY: WALKER-MERRICK F.H., CLARINDA, IA 51632
22b. FUNERAL ESTABLISHMENT LICENSE NUMBER:

23 PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Metastatic cancer - brain — Approximate Interval Between Onset and Death: 2 MOS
DUE TO (OR AS A CONSEQUENCE OF):
b. Cancer lung — 4 MOS
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I:
24 IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS? ☐ Yes ☐ No ☐ Unk.
25a. WAS AN AUTOPSY PERFORMED? ☐ Yes ☒ No
25b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? ☐ Yes ☐ No

26. MANNER OF DEATH: ☒ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
27a. DATE OF INJURY (Month, Day, Year):
27b TIME OF INJURY:
27c WAS INJURY ALCOHOL-RELATED? (Not limited to death) ☐ Yes ☐ No ☐ Unk.
27d. INJURY AT WORK? ☐ Yes ☐ No ☐ Unk.
27e. DESCRIBE HOW INJURY OCCURRED:
27f. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (specify):
27g. LOCATION (Street and Number or Rural Route Number, City or Town, State):

28a. (Specify) ☒ CERTIFYING PHYSICIAN ☐ MEDICAL EXAMINER/CORONER
28b To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title): Patrick B Harr MD
28c. DATE SIGNED (Month, Day, Year): 11-22-93
28d. TIME OF DEATH: 6 48 A
28e. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER OR CORONER) (Type or Print): Patrick B Harr MD, Maryville, Mo 64468
29a MO. LICENSE NUMBER: 32405
30 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? ☐ Yes ☒ No
31 NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print):
32. REGISTRAR'S SIGNATURE: Ruth J. Warner by P. Hatano
33 DATE RECEIVED BY LOCAL REGISTRAR (Month, Day, Year): 11-24-93

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STATE OF MISSOURI } ss

I HEREBY CERTIFY that this is an exact reproduction of the certificate for the person named therein as it now appears in the permanent records of the Bureau of Vital Records of the Missouri Department of Health. Witness my hand as County Registrar of Vital Statistics and the Seal of the Missouri Department of Health this date of

11-24-93

Ruth J. Warner
Registrar of Vital Statistics

MO 580-1103 (7-89)