

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

15663
Do not use this space.

1. PLACE OF DEATH
 (a) County Clark Registration District No. 920
 (b) Township Clark Primary Registration District No. 5859
 (c) City _____ (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME ~~Wm~~ ADAM LANSDOWN
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE whd 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr 2 1940

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
3

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Esabella Mo
Clark Co Mo

FATHER 13. NAME William H. Lansdown
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sovars Douglas Co Mo

MOTHER 15. MAIDEN NAME Biddie Snider
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Esabella Clark Co Mo

17. INFORMANT (ADDRESS) William H. Lansdown
Esabella Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Esabella DATE Apr 6 1940

19. FUNERAL DIRECTOR (ADDRESS) James Hale
Esabella Mo

20. FILED 4/10 1940 Mary F. Johnson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 5 1940

22. I HEREBY CERTIFY, That I attended deceased from no medicine used, 19____
 I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at 12 a.m.
 The principal cause of death and related causes of importance were as follows:
Hives
2000'

Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) Mary F. Johnson M. D.
Rhesdacia (Address)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 6,

District File Number 540-1229

Date Filed MAY 6 1944

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

.....L. E.....

No.....or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.)