

FILED SEP 10 1942

State File No.

Registration District No. 22263 Primary Registration District No. 5889 Registrar's No. 1

1. PLACE OF DEATH:
(a) County Ozark
(b) City or town Isabella
(c) Name of hospital or institution: Isabella Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County 77
(c) City or town Isabella
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME LEROY LANDSDOWN
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 28
year 1942 hour 8:55 minute 25 P. M.
21. I hereby certify that I attended the deceased from July 22
1942, to July 28 1942
that I last saw h. j. m. alive on July 25 1942
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race 0
6. (a) Single, widowed, married, divorced 0
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: Aug 16 1941
(Month) (Day) (Year)

Immediate cause of death Malnutrition Duration 3 wks.

8. AGE: Years _____ Months 11 Days 12 If less than one day _____ hr. _____ min.

Due to Septic Colitis
Due to _____

9. Birthplace Isabella Mo
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) _____

11. Industry or business Infant

Major findings: Of operations 119a Of autopsy _____

MOTHER FATHER { 12. Name Jessie Landsdown
13. Birthplace Wrensfield Mo
(City, town, or county) (State or foreign country)
14. Maiden name Murtyl Stiff
15. Birthplace Ark
(City, town, or county) (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Rozella Edwards
(b) Address Isabella Mo

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

17. (a) Burial (b) Date thereof July 29 1942
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Isabella Mo

While at work? _____ (Specify type of place) (e) Means of injury 0

18. (a) Signature of funeral director None
(b) Address _____
19. (a) 8-30-42 (b) Mary B Johnson
(Date received local registrar) (Registrar's signature)

23. Signature Wm J. Rollins D. or other _____
Address Isabella Ark Date signed 8-21-42

RECEIVED

District Health Officer No. 6,

District File Number 942-1321

Date Filed SEP 8 1942

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

12B
21-41
29288

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27851

Registration District No. 263

Primary Registration District No. 5889

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Ozark
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township) Rural
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location) _____
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL") _____
(d) Street No. _____
(If rural, give location) _____
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Le Roy Landsdown

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color white 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____
(Month) Aug (Day) 16 (Year) _____

8. AGE: Years _____ Months 11 Days 30 If less than one day _____ min.

9. Birthplace _____
(City, town, or county) _____ (State or foreign country) _____

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____
(City, town, or county) _____ (State or foreign country) _____

14. Maiden name _____

15. Birthplace _____
(City, town, or county) _____ (State or foreign country) _____

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) _____ (Month) (Day) (Year) _____

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Mary F. Johnson
(Date received local registrar) _____ (Registrar's signature) _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 28
year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____;
that I first saw him _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.

(Immediate cause of death) _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) _____ (County) _____ (State) _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____
(e) Means of injury _____

Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

