

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

24222
 Do not use this space.

FILED AUG 7 1943

1. PLACE OF DEATH
 (a) County Andrew Co Registration District No. 2
 (b) Township Jackson Primary Registration District No. 4006 Registered No. 83
 (c) City Fillmore (d) Street No. 1 St. 7
 (e) Length of residence in city or town where death occurred 38 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Nancy Narcissus Landess
 (a) Residence, No. Fillmore Mo St. (If nonresident, give city or town and State) 1
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (widow)
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Levi Landess
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 22 - 1868
 7. AGE YEARS 83 MONTHS 4 DAYS 24 If LESS than 1 day,hrs. ormin.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. housewife
 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) Marshall Mo
 13. NAME William White Bull
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri
 15. MAIDEN NAME Elizabeth Farris
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Huckey Co. Mo
 17. INFORMANT Mrs. Mattie Proffitt (ADDRESS) Fillmore Mo
 18. BURIAL, CREMATION, OR REMOVAL PLACE Fillmore DATE July 15 - 1943
 19. FUNERAL DIRECTOR Fred Terhune (ADDRESS) Savannah Mo
 20. FILED 7/17/43 J. H. Fritchman Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7/16 1943
 22. I HEREBY CERTIFY, That I attended deceased from 7/16 1943 to 7/16 1943
 I last saw her alive on 7/16 1943 Death is said to have occurred on the date stated above, at 2 p.m.
 The principal cause of death and related causes of importance were as follows:
Hypostatic Pneumonia Date of onset 7/15/43
Endocarditis 1913
 Other contributory causes of importance:
Chronic Cystitis
Old Age
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? No
 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) Ernest C. Conrad M. D. a
 (Address) Fillmore, Mo.
 7-17-43

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.

STATEMENT BY LICENSED EMBALMER

I, J. Fred Terhune, 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

J. Fred Terhune

Licensed Embalmer No. 1279

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.)

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHAUG 10 1943
State File No. _____Registration District No. 2Primary Registration District No. 4006Registrar's No. 83

1. PLACE OF DEATH:

- (a) County Andrew
 (b) City or town Fallmore
 (If outside city or town limits, write "RURAL" and name of township)
 (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 days3. (a) PRINT FULL NAME Nancy N. Fanders

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

4. Sex
- F
5. Color or race
- W
6. (a) Single, widowed, married, divorced
- W

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

7. Birth date of deceased
- Feb 22
-
- (Month) (Day) (Year)

8. AGE: Years
- 83
- Months
- 4
- Days _____
-
- 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) _____
-
- (Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month
- July
- Day
- 10
- Year
- 1943
- Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; to _____, 19____;

that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumoniaDue to EndocarditisDue to Chronic capitisOther conditions old age

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

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) (c) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

222525