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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED FEB 14 1944  
Registration District No. \_\_\_\_\_

Primary Registration District No. 2028

Registrar's No. 287

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

1. PLACE OF DEATH

(a) County Linn

(b) City or town Brookfield  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution 827 N. Main  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community 30 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn

(c) City or town Brookfield  
(If outside city or town limits, write "RURAL")

(d) Street No. 827 N. Main  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ANNA-ELIZABETH-LANUS

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 24  
year 1944 hour 9 minute 15 P. M.

21. I hereby certify that I attended the deceased from 1-18 1944, to 1-24 1944  
that I last saw her alive on 1-24 1944  
and that death occurred on the date and hour stated above.

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

6. (b) Name of husband or wife George Lanus 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept. 29 1857  
(Month) (Day) (Year)

Immediate cause of death	Duration
<u>Acute myocarditis</u>	<u>4 hrs</u>
<u>Influenza</u>	<u>10 da</u>
Other conditions (Include pregnancy within 3 months of death)	

8. AGE: Years Months Days If less than one day

86 3 25 hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

Major findings: Of operations 0

Of autopsy 0

PHYSICIAN 93a

Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business \_\_\_\_\_

12. Name Thomas Burns

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

14. Maiden name Adelia Golden

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

16. (a) Informant Mrs. Geo. A. Schreiner  
(b) Address Brookfield-Route 2

17. (a) Burial (b) Date thereof Jan. 27-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Michael Cemetery Brookfield

18. (a) Signature of funeral director Hill Chapel  
(b) Address Brookfield

19. (a) 1-27-1944 (b) W. H. Canan  
(Date received local registrar) (Registrar's signature)

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

(a) Accident, suicide, or homicide (specify) 0

(b) Date of occurrence 0

(c) Where did injury occur? 0  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
• While at work? 0 (Specify type of place) (e) Means of injury 0

23. Signature [Signature] (M. D. or other) 0  
Address Brookfield, Mo Date signed 1/27/44

**"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 J. H. Blacklock

Licensed Embalmer No. 2246

P. O. Address Brookfield Mo.

**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.**