

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

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

FILED AUG 2 1944

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

3024

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City, Mo  
(c) Name of hospital or institution: 214 West 15 - Room 9  
(d) Length of stay: In hospital or institution 28 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson  
(c) City or town Kansas City, Mo  
(d) Street No. 214 West 15 - Room 9  
(e) Citizen of foreign country? No  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Emma L Landes

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. 486-057267

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 17 year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Arteriosclerotic heart disease

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy inspection & history

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? \_\_\_\_\_

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

While at work \_\_\_\_\_ (Specify type of place) \_\_\_\_\_

23. Signature Chas E. Hoshner (M. D. or other) \_\_\_\_\_

Address 23rd & McCoy Date signed 7/20/44

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Walter F Landes 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased Dec - 14 - 1883

8. AGE:	Years	Months	Days	If less than one day
	<u>60</u>	<u>7</u>	<u>23</u>	_____ hr. _____ min.

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

10. Usual occupation House wife

11. Industry or business Clotting operator

12. Name Thomas L. Foster

13. Birthplace Tenn (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

14. Maiden name Rhoda-ann- Hittis

15. Birthplace Mo (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

16. (a) Informant Walter F Landes

(b) Address 214 West 15

17. (a) Burial (Burial, cremation, or removal) \_\_\_\_\_ (b) Date thereof July 22 44 (Month) (Day) (Year)

(c) Place: burial or cremation Clark Park

18. (a) Signature of funeral director W. P. Doehler

(b) Address 1415 East 15

19. (a) 7-22-44 (Date received local registrar) \_\_\_\_\_ (b) N. E. Brown (Registrar's signature) \_\_\_\_\_

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

MOTHER FATHER

---

---

**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.....

*Larry Buffington*

Licensed Embalmer No. *2956*

P. O. Address.....

*K. C. 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.**