

FILED OCT 6 1944

Registration District No. 6

Primary Registration District No. 5595

Registrar's No. 28

1. PLACE OF DEATH:

(a) County JEFFERSON  
(b) City or town RURAL North Jess  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution OWN HOME High Springs Mo  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 (Specify whether years, months or days)  
In this community 8 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County JEFFERSON  
(c) City or town RURAL 50  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT. day 12  
year 1944 hour 9 minute 30 A.M.  
21. I hereby certify that I attended the deceased from Apr 24 1944 to Sept 11 1944  
that I last saw him alive on 9/11/44  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Chronic Myocarditis  
Due to \_\_\_\_\_  
Chronic Arthritis  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)  
Major findings: 93d  
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) \_\_\_\_\_ (Means of injury)  
23. Signature Off. of Health (M. D. or other)  
Address 3157 1/2 Park Ave Date signed 9/12/44

3. (a) PRINT FULL NAME HUGO LANDSKRON JR.  
3. (b) If veteran, name war SPANISH AMERICAN  
3. (c) Social Security No. \_\_\_\_\_

4. Sex MALE 5. Color or race WHITE  
6. (a) Single, widowed, married, divorced Widower  
6. (b) Name of husband or wife LOUISE THOM  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: APRIL 9 1882  
(Month) (Day) (Year)

8. AGE: Years 62 Months 5 Days 7  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation INVALID

11. Industry or business OWN HOME RET. VETERAN

12. Name HUGO LANDSKRON

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant Hugo Landskron

(b) Address Home Springs Mo Rt #1

17. (a) BURIAL (b) Date thereof 9-16-1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation National Cem. Jeff Barrack #0

18. (a) Signature of funeral director John Brinkley

(b) Address Home Springs Mo

19. (a) 9/15/44 (b) Ch. Omer  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

OCT 23 1944

RECEIVED

District Health Officer. No.

District File Number

Date Filed 10-5-44

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

working under my personal supervision. Registered Apprentice No.

Signed *John H. Summer*

Licensed Embalmer No. 1470

P. O. Address. *House Springs 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.