

FILED NOV 23 1944
Registration District No. 23122

Primary Registration District No. 1000 Registrar's No. 9711

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri Pacific Hospital
(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

3. (a) PRINT FULL NAME Mary Alberta Landess

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

4. Sex Female 5. Color or race 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. January 12 1878
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
66 10 0 hr. min.

9. Birthplace De Soto Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Accounting Clerk

11. Industry or business Missouri Pacific Railroad

MOTHER FATHER

12. Name Warren Landess

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

14. Maiden name Clarissa Polite

15. Birthplace Washington County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant April Bechler
(b) Address De Soto, Missouri

17. (a) Burial (b) Date thereof 11-15-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation De Soto, Missouri

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) NOV 15 1944 (b) J. M. Brebeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County W.L.C.
(c) City or town St. Louis 7/7
(If outside city or town limits, write "RURAL") 7/9
(d) Street No. 5829 Amelia
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION.

20. DATE OF DEATH: Month Nov day 12
year 19 hour 2 minute 58 P.M.

21. I hereby certify that I attended the deceased from 10/5/44 19____ to 11/12/44 19____;
that I last saw her alive on 11/12/44 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinomatosis Duration _____

Due to Carcinoma Cervix 1 1/2 yrs

Due to _____

Other conditions H/O
(Include pregnancy within 3 months of death)

Major findings: Of operations Carcinoma Cervix PHYSICIAN _____

Of autopsy Carcinomatosis 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 C

23. Signature C. C. Drace (M. D. or other) _____
Address 1755 So. Grand Date signed 11/12/44

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

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

John Agnoski

Licensed Embalmer No. *3398*

P.O. Address.....

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.

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 9711

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Mo.
(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 days)

3. (a) PRINT FULL NAME Mary Alberta Sanders
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

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

8. AGE: Years _____ Months _____ Days _____
If less than one day _____ hr _____ 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 _____
(City, town, or county) (State or foreign country)

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) 12-2-46 (b) JFBredick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5829 Anheuser
(If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 12
year 1944 hour _____ minute _____ M.

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

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 _____

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

Address _____ Date signed _____

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

SUPPLEMENTAL

SEP 4 1945

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