

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAR 24 1945

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1092

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 4 days
(Specify whether)
 In this community 5 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL")
 (d) Street No. 3330 Prospect
(If rural, give location)
 (e) Citizen of foreign country? 1 (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME James Landes
 (b) If veteran, name war no
 (c) Social Security No. no

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month March day 7
 year 1945 hour 2 minute A. M.

4. Sex Male 5. Color or race wh
 6. (a) Single, widowed, married, divorced Widowed
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Nov 27th 1848
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 3 1945 to March 7 1945
 that I last saw him alive on March 7 1945
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
96 3 10 hr. _____ min.

Immediate cause of death Abscess of anterior abdominal wall
Cellulitis
 Due to Ischio rectal abscess
(non T.B.)
 Due to _____

9. Birthplace Retired Indiana
(City, town, or county) (State or foreign country)
 10. Usual occupation Retired Farmer

Other conditions 123:3
(Include pregnancy within 3 months of death)

MOTHER, FATHER

11. Industry or business _____
 12. Name William Landes
 13. Birthplace Indiana
(City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace Unknown
(City, town, or county) (State or foreign country)

Major findings: _____
 Of operations _____
 Of autopsy See above
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs Mary Land
 (b) Address 3330 Prospect
 17. (a) Removal (b) Date thereof 3-9-1945
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Coffey Missouri
 18. (a) Signature of funeral director Eylar Funeral Home
 (b) Address Kansas City Missouri
 19. (a) 3-8-45 (b) N. C. Brown
(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) _____
 (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) Mechanism of injury _____
 23. Signature Clark W. Seely MD
(M. D. or other)
 Address Med. Dir. Gen'l Hosp Date signed 3-9-45

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

1838

123-3-15
F-B
152

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 Chas E. Wilks

Licensed Embalmer No. 2644

P. O. Address Kansas City 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.