

10-300  
10-48

FILED JUL 31 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 24986  
6442

BIRTH NO. 44761-50 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No.

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) DR. LOUIS MO.		c. CITY (If outside corporate limits, write RURAL and give township) DR. LOUIS MO. 2259	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1512 Cole Dr		d. STREET ADDRESS (If rural, give location) 1512 Cole Dr	
3. NAME OF DECEASED a. (First) Bernice (Type or Print)		b. (Middle) HARDERS	
c. (Last) LANDERS		4. DATE OF DEATH (Month) (Day) (Year) 7 8 50	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 1950 -
9. AGE (In years last birthday) 1 Wk	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13a. FATHER'S NAME Lusk	13b. MOTHER'S MAIDEN NAME Lusk	14. NAME OF HUSBAND OR WIFE Lusk
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no; unknown) (If yes, give way or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Dunick Taylor 1500 Park	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphemia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Lobay Pneumonia DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. N.M.A.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	21f. HOW DID INJURY OCCUR? 7630
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
22. I hereby certify that I attended the deceased from _____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE J. B. Foster Deputy Registrar		23b. ADDRESS 1310 Clark	23c. DATE SIGNED 7/31/50
24a. FURTHER CREMATION REMOVAL (Specify)	24b. DATE JUL 27 PAID	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. JUL 28 PAID	REGISTRAR'S SIGNATURE J. B. Foster	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Rowland Mortuary Service Inc.	

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

If this body is not embalmed, fact should be so stated above.