

FILED NOV 6 1951

## STANDARD CERTIFICATE OF DEATH

State File No. 32563

|   |  |   |  |  |   |  |                                  |  |  |
|---|--|---|--|--|---|--|----------------------------------|--|--|
| BIRTH NO. _____   |  | REG. DIST. NO. 38   |  | PRIMARY REG. DIST. NO. 3006  |   | Registrar's No. 269  |                                  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Doone</u>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Mo</u> |   |  |                                  | b. COUNTY <u>Callaway</u>  |  |
| b. CITY OR TOWN <u>Columbia</u>   |  | c. LENGTH OF STAY (in this place) <u>72 da</u>  |  | c. CITY OR TOWN <u>Auxvasse</u>  |   | OR TOWN <u>0140</u>  |                                  |  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Ellis Fischel State Cancer</u>   |  |   |  | d. STREET ADDRESS (If rural, give location) <u>1</u>   |   |  |                                  |  |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>Leola</u>  |  |   | b. (Middle) <u>ANN</u>                             |  |   | c. (Last) <u>Lander</u>  |                                  |  |  |
| 4. DATE OF DEATH (Month) (Day) (Year)<br><u>10 26 51</u>  |  | 5. SEX <u>Female</u>  |  | 6. COLOR OR RACE <u>white</u>  |   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widow</u>  |                                  | 8. DATE OF BIRTH <u>Jan 27 1891</u>  |  |
| 9. AGE (In years last birthday) <u>60</u>   |  | IF UNDER 1 YEAR Months <u>8</u> Days <u>29</u>  |  | IF UNDER 1 HR. Hours <u></u> Min. <u></u>  |   | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>                                 |  |
| 11. BIRTHPLACE (State or foreign country) <u>Missouri</u>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A. Callaway</u>  |   |  |                                  |  |  |
| 13a. FATHER'S NAME <u>W. J. Sanders</u>   |  |   | 13b. MOTHER'S MAIDEN NAME <u>Martha E. Sixhorn</u> |  |   | 14. NAME OF HUSBAND OR WIFE <u>Claude Lander</u>   |                                  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>   |  | 16. SOCIAL SECURITY NO. <u>?</u>  |  | 17. INFORMANT'S SIGNATURE OR NAME <u>Hospital Record</u>   |   |  |                                  | ADDRESS  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.   |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Lymphosarcoma, generalized</u>                   |  |  |   |  |                                  | INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 - 3 yrs.</u>                           |  |
| ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br><br>DUE TO (b) _____<br><br>DUE TO (c) _____   |  | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |  |   |  |                                  |  |  |
| 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)  |   |  |                                  |  |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)  |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                              |  | 21f. HOW DID INJURY OCCUR?   |   |  |                                  |  |  |
| 22. I hereby certify that I attended the deceased from <u>July 25, 1951</u> , to <u>October 26, 1951</u> , that I last saw the deceased alive on <u>October 26, 1951</u> , and that death occurred at <u>9:15 Pm.</u> , from the causes and on the date stated above. |  |   |  |  |   |  |                                  |  |  |
| 23a. SIGNATURE (Degree or title) <u>John C. Tinsley Jr., M.D.</u>   |  |   |  | 23b. ADDRESS <u>Ellis Fischel State Cancer Hosp</u>  |   |  | 23c. DATE SIGNED <u>10-26-51</u> |  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 24b. DATE <u>10/27/51</u>   |  | 24c. NAME OF CEMETERY OR CREMATORY <u>Auxvasse</u>   |   | 24d. LOCATION (City, town, or county) (State) <u>Auxvasse, Mo.</u>   |                                  |  |  |
| DATE REC'D BY LOCAL REG <u>Oct 27 1951</u>  |  | REGISTRAR'S SIGNATURE <u>Mrs. R E Palmer</u>  |  |  | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Marylin Funeral Home, Auxvasse, Mo.</u> |  |                                  |  |  |

(Licensed Embalmer's Statement on Reverse Side)

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

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**RECEIVED** NOV 5 - 1951

DISTRICT HEALTH OFFICE No. 3

District File Number \_\_\_\_\_

Date Filed NOV 5 - 1951 \_\_\_\_\_

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**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.

Student Embalmer No. ....

Signed.....  
Student Embalmer

Signed Walter J. Haine, Jr.

Licensed Embalmer No. 4559

P. O. Address Fulton, Me

**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.