

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28188

State File No. ....

FILED SEP 9 - 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 100 PRIMARY REG. DIST. NO. 5385 Registrar's No. 74

0330

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

1. PLACE OF DEATH a. COUNTY <u>Dent</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Dent</u>	
b. CITY OR TOWN <u>rural-Meramec typ</u> c. LENGTH OF STAY (In this place) <u>8 hrs</u>		c. CITY OR TOWN <u>Salem</u> d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>XX</u>		e. STREET ADDRESS (If rural, give location) <u>Springcreek typ rt 4</u> <span style="float: right;">0330</span>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Luther</u>	b. (Middle) <u>Milton</u>	c. (Last) <u>Land</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>8/29/53</u>
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5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Jan 22 1904</u>	9. AGE (In years last birthday) <u>49</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>farm work</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Dent Co Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>0</u>
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13a. FATHER'S NAME <u>Wm Land</u>	13b. MOTHER'S MAIDEN NAME <u>Alice Land</u>	14. NAME OF HUSBAND OR WIFE <u>Nellie Land</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>X</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Nellie Land</u> ADDRESS <u>Salem Mo rt 4</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary occlusion</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>4201</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 4-I-47, 1947, to 8-31-53, 1953, that I last saw the deceased alive on 1-27-53, 1953, and that death occurred at 5:30Pm., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u> (Degree or title?)	23b. ADDRESS <u>Salem, Mo.</u>	23c. DATE SIGNED <u>8-31-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>8-31-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove</u>	24d. LOCATION (City, town, or county) (State) <u>Salem Mo</u>
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DATE REC'D BY LOCAL REG. <u>8-31-53</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>[Address]</u>
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OCT 15 1953

SEP 16 1953

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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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  
*Carl K. Johnson*

Licensed Embalmer No. 23.....

P. O. Address Salem.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.