

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

Dr. John Williams
State File No. 4518
259
Registrar's No. _____

FILED MAR 15 1954

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>GREENE</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SPRINGFIELD</u>		c. CITY OR TOWN <u>SPRINGFIELD</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>1 yr.</u>		e. STREET ADDRESS (If rural, give location) <u>721 W. DELLA ST.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>721 W. DELLA ST.</u>		0346	
3. NAME OF DECEASED (Type or Print) a. (First) <u>LANDON</u> b. (Middle) <u>TAYLOR</u> c. (Last) <u>DAY</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH 7, 1954</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>FEB. 13, 1883</u>
9. AGE (In years last birthday) <u>71</u>		10. UNDER 1 YEAR (Months) _____	11. UNDER 4 HRS. (Hours) _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>KANSAS CITY, KANSAS</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>JOSIAH DAY</u>	
13b. MOTHER'S MAIDEN NAME <u>NORA HAIGHT</u>		14. NAME OF HUSBAND OR WIFE <u>SADIE H. DAY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>SADIE H. DAY, 721 W. DELLA ST.</u>		ADDRESS _____	

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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Generalized Carcinomatosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <u>Cancer of the Bladder</u> DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				

19a. DATE OF OPERATION <u>2-6-53</u>	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <u>181X</u>
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 9-1 1954 to 3-7 1954, that I last saw the deceased alive on 3-6 1954, and that death occurred at 8:45 a. m., from the causes and on the date stated above.

23a. SIGNATURE (Describe or title) <u>Chas. Williams</u>		23b. ADDRESS <u>Springfield, Mo</u>		23c. DATE SIGNED <u>3-8-54</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>3/7/54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>NEAR MT. VIEW MO.</u>	24d. LOCATION (City, town, or county) (State) <u>Mountain View, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>3-9-54</u>	REGISTRAR'S SIGNATURE <u>Edith Williams</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>500 E. Walnut Springfield, Mo.</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-48

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 *Levin L. Shalby*.....

Licensed Embalmer No. *4816*

P. O. Address *Livingston*

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.