

FILED MAY 7 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13061**

BIRTH NO. _____ REG. DIST. NO. **314** PRIMARY REG. DIST. NO. **4459** Registrar's No. **20**

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1. PLACE OF DEATH a. COUNTY St. Clair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Clair	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Osceola		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Osceola	
c. LENGTH OF STAY (In this place) 18 years		d. STREET ADDRESS (If rural, give location) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____			

3. NAME OF DECEASED (Type or Print)	a. (First) Josie	b. (Middle) Landes	c. (Last) Daniel	4. DATE OF DEATH (Month) (Day) (Year) Apr: 17, 1954
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May 13, 1869	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeping		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) Osceola Missouri		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Thomas B. Mey	13b. MOTHER'S MAIDEN NAME Amelia Landes	14. NAME OF HUSBAND OR WIFE Deceased
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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) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Frances Daniel, Osceola Missouri	ADDRESS _____
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 5 da
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) cerebral hemorrhage		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) hypertension DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. myocardial changes			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION 331X	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from **1953** to **4-17**, 1954, that I last saw the deceased alive on **4-16**, 1954, and that death occurred at **1:55** A.M., from the causes and on the date stated above.

23a. SIGNATURE Hubert Seewers M.D. (Degree or title)	23b. ADDRESS Osceola Mo.	23c. DATE SIGNED 4-18-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-18-54	24c. NAME OF CEMETERY OR CREMATORY Osceola	24d. LOCATION (City, town, or county) (State) Osceola Missouri
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DATE REC'D BY LOCAL REG. 4-18-54	REGISTRAR'S SIGNATURE Hubert Seewers	25. FUNERAL DIRECTOR'S SIGNATURE F. B. Goodrich	ADDRESS Osceola
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

JUN 26 1958

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 J. B. [Signature]

Licensed Embalmer No. 3038

P. O. Address Osceola Md

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.