

FILED SEP 27 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29865

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>1022</u>			
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>					
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>St. Joseph</u> )		c. LENGTH OF STAY (In this place) <u>66 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Joseph</u>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2616 Locust St.</u>				d. STREET ADDRESS (If rural, give location) <u>2616 Locust St.</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>LEO</u>			b. (Middle)		c. (Last) <u>LANKFORD, SR.</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 14, 1954</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>May 30, 1884</u>		9. AGE (In years last birthday) <u>70</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trucking &amp; Hauling</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Trucking</u>		11. BIRTHPLACE (State or foreign country) <u>Canton, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>Robert L. Lankford</u>			13b. MOTHER'S MAIDEN NAME <u>Charlotte Dade</u>		14. NAME OF HUSBAND OR WIFE <u>Mary Allen Lankford</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Mary Lankford, 2616 Locust St., City</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>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (b) <u>Chronic Myocarditis</u>		<u>1 yr.</u>			
				DUE TO (c) <u>Enlarged prostate bleeding</u>		<u>not sure</u>			
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>610 X</u>						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)					
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>Sept 19 53</u> , to <u>Sept 14, 1954</u> , that I last saw the deceased alive on <u>Sept 14, 1954</u> , and that death occurred at <u>3:20A m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Collis Roundy M.D.</u>				23b. ADDRESS <u>Kirkpatrick Bldg., City</u>		23c. DATE SIGNED <u>9-15-54</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sept 17, 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Ashland Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>Sept. 24, 1954</u>		REGISTRAR'S SIGNATURE <u>Ethel M. Allison</u>		FURNERAL DIRECTOR'S SIGNATURE <u>Wm. H. Alexander</u>		ADDRESS <u>St. Joseph, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

200  
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 .....  
Student Embalmer

Signed..... *Wm. H. Alexander*

Licensed Embalmer No. *4450*

P. O. Address. *St. Joseph, Mo.*

**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.