

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38298

State File No.

FILED DEC 1 1954

BIRTH NO. _____ REG. DIST. NO. 275 PRIMARY REG. DIST. NO. 3053 Registrar's No. 216

1. PLACE OF DEATH a. COUNTY PHELPS		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before a. STATE MO b. COUNTY FRANKLIN (Institution).	
b. CITY OR TOWN ROLLA	c. LENGTH OF STAY (in this place)	c. CITY OR TOWN SULLIVAN MO	d. Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION PHELPS COUNTY HOSPITAL		e. STREET ADDRESS (If rural, give location) 036 1/1	

3. NAME OF DECEASED (Type or Print)	a. (First) SHIRLEY	b. (Middle) MAXINE	c. (Last) POUNDS LANDING	4. DATE OF DEATH (Month) (Day) (Year) 11 23 1954
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 5-19-1934	9. AGE (In years last birthday) 20	IF UNDER 1 YEAR Months 6 Days 4	IF UNDER 24 HRS. Hours 4 Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Factory	10b. KIND OF BUSINESS OR INDUSTRY Shoes	11. BIRTHPLACE (City and State or Foreign Country) ST. LOUIS MO	12. CITIZEN OF WHAT COUNTRY? U.S.A
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13a. FATHER'S NAME John W Pounds	13b. MOTHER'S MAIDEN NAME Leona Record	14. NAME OF HUSBAND OR WIFE Edward Landing
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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)	16. SOCIAL SECURITY NO. 487-26-1276	17. INFORMANT'S SIGNATURE OR NAME Edward Landing	ADDRESS Sullivan Mo
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Post Partum Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 7 Hours
	ANTECEDENT CAUSES DUE TO (b) Everted Uterus		
	DUE TO (c) Childbirth		
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	20. AUTOPSY? YES <input checked="" 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 Nov 24 1954, to Nov 23 1954, that I last saw the deceased alive on Nov 23 1954, and that death occurred at 8:30 p. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Robert McLaughlin M.D.	23b. ADDRESS Sullivan Mo.	23c. DATE SIGNED Nov. 24-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11-26-1954	24c. NAME OF CEMETERY OR CREMATORY Cave Springs	24d. LOCATION (City, town, or county) (State) Burial of Sullivan Mo.
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DATE REC'D BY LOCAL REG. Nov. 24, 1954	REGISTRAR'S SIGNATURE Nadine C. Stoll	25. FUNERAL DIRECTOR'S SIGNATURE Wesley P. Shopper	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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

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

Student
Signature of Student Embalmer

Signed Paul F. Knodden

Licensed Embalmer No. 563

P. O. Address Sullivan

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.