

FILED NOV 29 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39313

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 2604

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| 1. PLACE OF DEATH a. COUNTY St. Louis | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri COUNTY St. Louis | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Robertson | | c. CITY OR TOWN Robertson 407 10 | |
| c. LENGTH OF STAY (In this place) 6 Yrs. | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Rt. 1 Box 95 Robertson Mo | | | |
| STREET ADDRESS (If rural, give location) Rt. 1 Box 95 Robertson Mo. | | | |

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| 3. NAME OF DECEASED (Type or Print) | a. (First) Jennie | b. (Middle) M. | c. (Last) Layland | 4. DATE OF DEATH (Month) (Day) (Year) Nov. 7 1955 |
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| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Sept. 14, 1891 | 9. AGE (In years last birthday) 64 | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Min. _____ |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home | 10b. KIND OF BUSINESS OR INDUSTRY Housewife | 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 August Sommer | 13b. MOTHER'S MAIDEN NAME Mary Knickmeyer | 14. NAME OF HUSBAND OR WIFE Herbert H. Layland |
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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. 494-26-4694 | 17. INFORMANT'S SIGNATURE OR NAME Herbert H. Layland | ADDRESS Rt. 1 Robertson 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, asthenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH 3 yrs. |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Epidermoid Carcinoma of Tongue with metastases | | |
| | 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. | | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 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) (m.) | 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 July 8, 1955, to July 13, 1955, that I last saw the deceased alive on November 7, 1955, and that death occurred at 6:00 a.m., from the causes and on the date stated above.

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| 23a. SIGNATURE <i>C. J. McMillian, M.D.</i> (Degree or title) M. D. | 23b. ADDRESS Barnes Hospital | 23c. DATE SIGNED 11/7/55 |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 11/9/1955 | 24c. NAME OF CEMETERY OR CREMATORY Zion Cemetery | 24d. LOCATION (City, town, or county) (State) St. Louis County Mo. |
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| DATE REC'D BY LOCAL REG. 11-7-55 | REGISTRAR'S SIGNATURE Herbert P. Dombke M.D. | 25. FUNERAL DIRECTOR'S SIGNATURE Collier Mortuary | ADDRESS 10123 St. Chas. Rd. |
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WRITE PLAINLY—USING UNFADING 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 Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Sheldon Collier*.....

Licensed Embalmer No. *338*

P. O. Address *10123 St. 4*

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.)