

FILED SEP 27 1956

THE DIVISION OF HEALTH - MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30824**
3922

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Barry</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>30 Min.</u>	c. CITY OR TOWN <u>Monett</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>6306 Morningside DR.</u>		STREET ADDRESS (If rural, give location) <u>507 6th Street</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Edna</u> b. (Middle) <u>Mae</u> c. (Last) <u>Landrum</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>September 5, 1956</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	
8. DATE OF BIRTH <u>November 22, 1881</u>		9. AGE (In years last birthday) <u>74</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>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Clinton Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					

13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>William F. Landrum</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Sally Jones 5322 Sycamore Road Park, Mo.</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>	
<p>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CORONARY Occlusion</u>			
		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.		<u>4201</u>	

19a. DATE OF OPERATION		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)	
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?	

22. I hereby certify that I attended the deceased from 8-23, 1956, to 9/4, 1956, that I last saw the deceased alive on 9/4/56, 1956, and that death occurred at 2:00 P. m., from the causes and on the date stated above.

23a. SIGNATURE <u>Leo F. Cooper M.D.</u> (Degree or title)		23b. ADDRESS <u>5930 Yale Mission, Kan.</u>		23c. DATE SIGNED <u>9/5/56</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>9-5-1956</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Spring Valley Cemetery</u>	
24d. LOCATION (City, town, or county) (State) <u>Verona Missouri</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>P.W. Newcomer's Sons Mission K</u>			
DATE REC'D BY LOCAL REG. <u>9-6-56</u>		REGISTRAR'S SIGNATURE <u>Irva Marshall</u>			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
Leo F. Cooper

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 *Herbert A Jones*.....

Licensed Embalmer No. *4927*.....

P. O. Address *Minim Ks*.....

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.