

Health,
& Welfare
Public
Service

FILED MAY 20 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18209

STATE FILE NUMBER

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 59

1. PLACE OF DEATH a. COUNTY <u>PIKE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>PIKE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LOUISIANA</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>LOUISIANA</u> 0420 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>PIKE CO. HOSP. 40 YRS</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>R.F.D #2</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>AUGUST</u> Middle <u>LANDIN</u> Last <u>LANDIN</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>8</u> Year <u>1957</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 31, 1869</u>		9. AGE (In years last birthday) <u>87</u> IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u> Hours <u>0</u> Min. <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during past or preceding year) <u>SHOE REPAIRMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>GERMANY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>LEWIS LANDIN</u>			
13b. MOTHER'S MAIDEN NAME <u>ANNA STEFFEN</u>		14. NAME OF HUSBAND OR WIFE <u>MYRTLE LANDIN</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 Address <u>MRS MYRTLE LANDIN, LOUISIANA, MO</u>	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Ch. Blom. infect.</u>		<u>yes</u>
	DUE TO (c) <u>592x</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>pneumonia, hypoglycemia, Cerebr. vascular accident</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour <u>11:50</u> Month, Day, Year <u>4/16/57</u> a.m. p.m.					

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>4/16/57</u> to <u>5/8/57</u> and last saw him alive on <u>5/8/57</u> Death occurred at <u>11:50 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>J. A. McCallister MD</u>			22b. ADDRESS <u>Louisiana Mo.</u>		22c. DATE SIGNED <u>5/9/57</u>

23a. BURIAL, CREMATION, REINTERMENT <u>BURIAL</u>		23b. DATE <u>MAY 10, 1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GREENWOOD CEM. - LOUISIANA, MO.</u>		23d. LOCATION (City, town, or county) (State) <u>LOUISIANA, MO.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>GEO. M. COLLIER</u>			25. DATE RECD. BY LOCAL REG. <u>MAY 10, 1957</u>		26. REGISTRAR'S SIGNATURE <u>Bernice Collier</u>		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Color, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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2414
MAY 13 1904
THE COLLEGE
NEW

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 *Geo M. Collier*

Licensed Embalmer No. *3839*
P. O. Address *Louisiana*

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.