

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20526**

FILED JUL 8 1957

BIRTH NO. _____ REG. DIST. NO. **87** PRIMARY REG. DIST. NO. **4150** Registrar's No. **8**

1. PLACE OF DEATH a. COUNTY Crawford		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Crawford	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Bourbon		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Bourbon	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS 0280 (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) Howard b. (Middle) G c. (Last) Landon			4. DATE OF DEATH (Month) (Day) (Year) July 3 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 11 1875	9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Days 1 IF UNDER 24 HRS. Hours 22 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Merchant		10b. KIND OF BUSINESS OR INDUSTRY Merchant		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY U.S.A.					

13a. FATHER'S NAME James Landon		13b. MOTHER'S MAIDEN NAME Alice Turnbull		14. NAME OF HUSBAND OR WIFE May Landon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME May Landon ADDRESS Bourbon Mo.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*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>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Brocho pneumonia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Malnutrition DUE TO (c) Sensitivity		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Congestive Heart Failure			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION H34.1		20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO

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)	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 **4-27, 1957** to **7-3, 1957**, that I last saw the deceased alive on **7-2, 1957**, and that death occurred at **7 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) C. E. Carnahan MD	23b. ADDRESS Bourbon, Mo.	23c. DATE SIGNED 7-3-57
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE July 5-57	24c. NAME OF CEMETERY OR CREMATORY Bourbon Cemetery	24d. LOCATION (City, town, or county) (State) Bourbon Mo.
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DATE REC'D BY LOCAL REG. 7-5-57	REGISTRAR'S SIGNATURE [Signature]	25. FEDERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS [Address]
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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
Student Embalmer

Signed *James P. Shaffer*

Licensed Embalmer No. *2692*

P. O. Address _____

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 this body is not embalmed, fact should be so stated above.