

Health, & Welfare  
Public  
Service

FILED JUL 12 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

57 021 174  
STATE FILE NUMBER  
2881

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

300  
1-57

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>Sullivan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Browning</u> 1050 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>Research Hospital</u> Length of stay in lb <u>5 days</u>		d. STREET ADDRESS <u>NE 1/2 mile</u> (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>SIGMON</u> Middle <u>CLAY</u> Last <u>LANTZ</u>			4. DATE OF DEATH Month <u>June</u> Day <u>19</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>March 13 1891</u>	9. AGE (In years last birthday) <u>66</u> IF UNDER 1 YEAR Months Days Hours Min.
--------------------	-------------------------------	---	--	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired Mechanical</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Heating Equipment</u>	11. BIRTHPLACE (City, and state or country) <u>Linn County Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--	---	---	---

13a. FATHER'S NAME <u>Lot C. Lantz</u>	13b. MOTHER'S MAIDEN NAME <u>Jennie Moore</u>	14. NAME OF HUSBAND OR WIFE <u>Lola Frances Lantz</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>-</u>	17. INFORMANT <u>Mrs. Lola Lantz, Browning Mo</u> Address
--	-------------------------------------	---

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>Melanotic Ca. Probable Hypomelanoma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>180X</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		

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 _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT <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>10-15-57</u> to <u>6-19-57</u> and last saw her alive on <u>6-19-57</u> Death occurred at <u>7:25 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <u>Don W. Marshall M.D.</u> (Degree or title)	22b. ADDRESS <u>924 Post Bldg.</u>	22c. DATE SIGNED <u>6/19/57</u>
--	---------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>6/19/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>-</u>	23d. LOCATION (City, town, or county) (State) <u>Browning Mo</u>
---	-----------------------------	--	---

24. FUNERAL DIRECTOR <u>Wade Motuary, Browning Mo</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>6-20-57</u>	26. REGISTRAR'S SIGNATURE <u>neva minshall</u>
---	--	---

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Don A. Black

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

KP  
4

### 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 *John R. Didman* .....

Licensed Embalmer No. *4531* .....

P. O. Address *Kansas City,* .....

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.