

FILED JAN 8 1958

STANDARD CERTIFICATE OF DEATH

44454
STATE FILE NUMBER
5823

Registration District No. 149 Primary Registration District No. 1002

Registrar's No. 5823

S. 300
v. 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>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>KANSAS CITY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4824 PARK</u>		Length of stay in lb <u>17 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>4824 Park</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>S</u> Last <u>Landes</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>8.</u> Year <u>1957</u>		
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAUC.</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>12-22-1911</u>	9. AGE (In years last birthday) <u>45</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service Station Attendant</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>SERVICE STATION</u>	11. BIRTHPLACE (City and state or country) <u>JAMESON, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Hubert Landes</u>	13b. MOTHER'S MAIDEN NAME <u>Chloe Collins</u>	14. NAME OF HUSBAND OR WIFE <u>Alpha Landes</u>
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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) <u>NO</u>	16. SOCIAL SECURITY NO. <u>500-072-005</u>	17. INFORMANT <u>Mrs. Alpha Landes</u> Address <u>4824 Park</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>Myocardial infarction, myocarditis</u>		INTERVAL BETWEEN ONSET AND DEATH. <u>415+</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arterio sclerotic Hypertension</u>	
	DUE TO (c) <u>Rheumatic fever-inactive</u>	
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? <u>2</u> 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.)
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20c. TIME OF INJURY Hour . Month, Day, Year 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
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21. I attended the deceased from <u>Jan 157</u> to <u>Dec 8, 57</u> and last saw <u>him</u> alive on <u>Nov 26 1957</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>W. F. Spiller</u> (Degree or title) <u>D.O.</u> <u>2</u>	22b. ADDRESS <u>6614 Montgall</u>	22c. DATE SIGNED <u>12-9-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Dec. 10, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Brown Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Callaway, Missouri</u>
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24. FUNERAL DIRECTOR <u>Muehlebach</u> ADDRESS <u>6800 T. Road</u>	25. DATE RECD. BY LOCAL REG. <u>12-10-57</u>	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>
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(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

W. F. SPILLER

MEDICAL CERTIFICATION

6614
Ar Speller
Montgall.



See 3-5-5-80

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 R. P. Nichols

Licensed Embalmer No. 4997
P. O. Address V. C. Mo.

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.