

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-021961

STATE FILE NUMBER

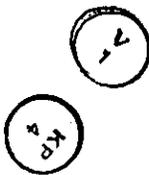
FILED JUL 14 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3077

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>TRINITY LUTHERAN</u>			Length of stay in 1b <u>59 YRS.</u>		d. STREET ADDRESS (If outside, give location) <u>1-W-65 TERRACE</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>OSCAR</u> Middle <u>FERDINAND</u> Last <u>LANDER</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>19</u> Year <u>1958</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>DEC-23-1875</u>		9. AGE (In years last birthday) <u>82</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>RETIRED 15 YRS</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>STOCK BROKER</u>		11. BIRTHPLACE (City and state or country) <u>LAWRENCE, KANSAS</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13a. FATHER'S NAME <u>JACOB LANDER</u>				13b. MOTHER'S MAIDEN NAME <u>KATHERINE REICHTH</u>				14. NAME OF HUSBAND OR WIFE <u>FRIEDA LANDER</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>486-05-1427</u>		17. INFORMANT Address <u>FRIEDA LANDER 1-W-65 TER. K.C. MO</u>							
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>Cerebral Arteriosclerosis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>10 years +</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Generalized Arteriosclerosis</u>										10 years +			
DUE TO (c) _____										3348			
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 _____ Month, Day, Year 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>12/13/47</u> to <u>6/19/58</u> and last saw ^{her} him alive on <u>6/18/58</u> Death occurred at <u>11:00 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>R.R. Becker M.D.</u>					22b. ADDRESS <u>4000 Baltimore Kansas City, Mo.</u>					22c. DATE SIGNED <u>6/20/58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>JUNE-21-1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. MORIAH</u>			23d. LOCATION (City, town, or county) <u>KANSAS CITY</u>			(State) <u>Mo</u>			
24. FUNERAL DIRECTOR ADDRESS <u>D.W. NEWCOMER'S SONS KAN. CITY, MO</u>					25. DATE RECD. BY LOCAL REG. <u>6-20-58</u>		26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>						

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
R. R. Becker
All diseases in Part I must be causally related.



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 *Albert H. Savage*

Licensed Embalmer No. *4812*

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.