RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS AUG 20 1959

59-031215
STATE FILE NUMBER

Registration District No. 347 Primary Registration District No. _____ Registrar's No. 30

1. PLACE OF DEATH
a. COUNTY Stone
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Near Viola
Length of stay in 1b years
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5 Mi. E. of Viola
Inside Limits Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Stone
c. CITY OR TOWN Near Viola
Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) 5 Mi. E. of Viola
Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First SUSIE Middle KATHERINE Last LANDERS
4. DATE OF DEATH Month July Day 20. Year 1959
5. SEX Female
6. COLOR OR RACE White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH 4-14-1886
9. AGE (last birthday) 73
IF UNDER 1 YEAR Months Days; IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Ozark, Missouri
12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Hosea Bilyeu
13b. MOTHER'S MAIDEN NAME Charlotte Cecil
14. NAME OF HUSBAND OR WIFE Elmer Landers
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. Yes
17. INFORMANT Mrs. Lonnie Hendrickson Address Rt.1 Berryville. Ark.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Ca of Pancreas
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 7-12-59, to _____ and last saw her/~~him~~ alive on 7-12-59
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Charles H. Prine (Degree or title) M.D.
22b. ADDRESS Cassville, Missouri
22c. DATE SIGNED 8-1-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 7-22-59
23c. NAME OF CEMETERY OR CREMATORY McCollough Cemetery
23d. LOCATION (City, town, or county) (State) Stone County, Mo.

24. FUNERAL DIRECTOR Nelson Funeral Home ADDRESS Berryville, Ark.
25. DATE RECD. BY LOCAL REG. 7-9-15-1959
26. REGISTRAR'S SIGNATURE Mrs. Elmer Brown

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to cor
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.