

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036852

FILED VS NOV 12 1959

Registration District No. 195 Primary Registration District No. _____ Registrar's No. 89-59 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>McDonald</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>McDonald</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Prairie</u>		Length of stay in 1b <u>Lifetime</u>		c. CITY OR TOWN <u>Anderson</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Anderson Route 2</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Anderson Route 2</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nawil</u> Middle <u>Dean</u> Last <u>Landon</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>30</u> Year <u>1959</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>5-21-1937</u>	9. AGE (last birthday) <u>22</u>	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) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>Anderson, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Curge Harmon Landon</u>			13b. MOTHER'S MAIDEN NAME <u>Effie Hildred Tye</u>			14. NAME OF HUSBAND OR WIFE <u>None</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>None</u>		17. INFORMANT <u>Curge Landon Anderson, Missouri</u>			Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u>								
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								
DUE TO (b) <u>Morquio's Disease</u>								
DUE TO (c) <u>Hereditary Osteochondrystrophy</u>								
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.		Month, Day, Year						
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
21. I attended the deceased from <u>October 29 -59</u> , to _____, and last saw <u>him</u> alive on <u>October 29-59</u>				Death occurred at <u>8:15 A.m</u> on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <i>[Signature]</i> (Degree or title)				22b. ADDRESS <u>Anderson Mo</u>			22c. DATE SIGNED <u>11/3/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Nov. 1, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cummings Chapel</u>			23d. LOCATION (City, town, or county) (State) <u>McDonald County, Mo.</u>			
24. FUNERAL DIRECTOR <u>Roller Funeral Home, Anderson, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Mo. 11-5-59</u>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

DOCUMENT

MEDICAL CERTIFICATION

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 _____

Signature of Student Embalmer

Signed Robert C. Keller

Licensed Embalmer No. 5062

P. O. Address Anderson, 7

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