

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

=60-000901

STATE FILE NUMBER

FILED VS FEB 2 1960

Registration District No. 107 Primary Registration District No. 3019 Registrar's No. 19

|   |  |   |  |   |   |  |  |   |       |  |
|---|--|---|--|---|---|--|--|---|-------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Dunklin</u>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Arkansas</u> b. COUNTY <u>Clay</u>                     |   |  |  |   |       |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR <u>Kennett</u><br>TOWN  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>      |  | 40 <sup>3</sup> CITY OR TOWN <u>Rector</u>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |   |       |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Dunklin Co. Hosp.</u>   |  |   | Length of stay in 1b<br><u>2 wks.</u>  |   | d. STREET ADDRESS (If outside, give location)<br><u>703 Greenville</u>        |  | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> |   |       |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Carl</u> Middle <u>Manson</u> Last <u>Landis</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>Jan.</u> Day <u>22</u> Year <u>1960</u>  |   |  |  |   |       |  |
| 5. SEX<br><u>Male</u>   |  | 6. COLOR OR RACE<br><u>White</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><u>Nov. 14, 1897</u>   |  | 9. AGE (In years last birthday) <u>62</u><br>IF UNDER 1 YEAR: Months _____ Days _____<br>IF UNDER 24 HRS.: Hours _____ Min. _____ |       |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Salesman</u>  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Ford Agency</u>                                      |   | 11. BIRTHPLACE (City and state or country)<br><u>Arkansas</u> / <u>U.S.A.</u> |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |   |       |  |
| 13. FATHER'S NAME<br><u>Samuel Landis</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Ruth Wilson</u>  |   |  |  |   |       |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>  |  |   | 16. SOCIAL SECURITY NO.<br><u>432 09 5490</u>  |   | 17. INFORMANT<br><u>Mrs. Mary Ruth Seegraves</u>                              |  |  | Address   |       |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u>   |  |   |  |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>days</u>   |       |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  |  | DUE TO (b) <u>arterio-sclerotic heart dis. with</u>                                       |  | DUE TO (c) <u>cerebral thrombosis</u>   |   |  |  | year<br><u>days</u>   |       |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>4200</u>   |  |   |  |   |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>                        |       |  |
| 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<br>Hour _____ a. m. _____ p. m. _____<br>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>Jan 60</u> to <u>22 Jan 60</u> and last saw <sup>him</sup> <del>her</del> alive on <u>22 Jan 60</u><br>Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated. |  |   |  |   |   |  |  |   |       |  |
| 22a. SIGNATURE (Degree or title)<br><u>Joe A. Zimmerman, M.D.</u>   |  |   |  |   | 22b. ADDRESS<br><u>Kennett Mo.</u>  |  |  | 22c. DATE SIGNED<br><u>25 Jan 60</u>  |       |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City, town, or county)  |  | (State)   |       |  |
| <u>Burial</u>   |  | <u>Jan. 24, 1960</u>  |  | <u>Woodland Heights</u>   |   | <u>Rector, Arkansas</u>  |  |   |       |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><u>Irby Funeral Home, Rector, Ark.</u>  |  |   |  | 25. DATE RECD. BY LOCAL REG.<br><u>Jan 30-1960</u>  |   | 26. REGISTRAR'S SIGNATURE<br><u>Carl Husband</u>                                     |  |   |       |  |

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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Co. file No. 260-38

APR 15 1960

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.....

Licensed Embalmer No.....

P. O. Address .....

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.