

ENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4484

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>mo</u> b. COUNTY <u>Jackson</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in lb <u>5 wks.</u>	c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Cateogathic Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4801 E. 40th Terrace</u>	
3. NAME OF DECEASED (Type or print) First <u>Laurie</u> Middle <u>Sue</u> Last <u>Landes</u>			4. DATE OF DEATH Month <u>Aug</u> - Day <u>31</u> - Year <u>1960</u>		
5. SEX <u>Female</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>7/24/1960</u>	9. AGE (last birthday) Months <u>1</u> Days <u>6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Kansas City, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Bugene D Landes</u>		13b. MOTHER'S MAIDEN NAME <u>Sandra Turner</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Bugene Landes 4801 E 40 Terr.</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>Bronchopneumonia</u> DUE TO (b) <u>acute enteritis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>4 days</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 _____ 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
21. I attended the deceased from <u>Aug. 27, 1960</u> to <u>Aug. 31, 1960</u> and last saw her <u>him</u> alive on <u>Aug. 30, 1960</u> . Death occurred at <u>6:35</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Glenn W. Springer, D.O.</u>			22b. ADDRESS <u>5702 St. John ave.</u>		22c. DATE SIGNED <u>8-31-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9/2/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>	
24. FUNERAL DIRECTOR <u>C. N. Blackman &amp; Son Inc. Mo</u>		25. DATE RECD. BY LOCAL REG. <u>9-1-60</u>	26. REGISTRAR'S SIGNATURE <u>H. L. Dwyer</u>		

DOCUMENT

BY AFFIDAVIT OF Glenn W. Springer MEDICAL CERTIFICATION

**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 W.C. Rinne

Licensed Embalmer No. 4879

P. O. Address K.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: