

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-031970
STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 987

AMENDED

FILED OCT 9 1961

DATE AMENDED

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| a. COUNTY Buchanan | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph | a. STATE Missouri | b. COUNTY Buchanan |
| Length of stay in 1b 72 Years | | c. CITY OR TOWN St. Joseph | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 106 South 22nd St. | | d. STREET ADDRESS (If outside, give location) 106 South 22nd St. | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|-------------------------------------|----------------------|----------------------|------------------------|------------------|---------------------------|------------------|---------------------|
| 3. NAME OF DECEASED (Type or print) | First Lula | Middle Mae | Last Madison | 4. DATE OF DEATH | Month September | Day 26 | Year 1961 |
|-------------------------------------|----------------------|----------------------|------------------------|------------------|---------------------------|------------------|---------------------|

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|-------------------------|----------------------------------|---|--|-------------------------------------|---------------------------|---------------------|
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 11, 1875 | 9. AGE (last birthday) 85 | IF UNDER 1 YEAR Months | IF UNDER 24 HR Min. |
|-------------------------|----------------------------------|---|--|-------------------------------------|---------------------------|---------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (City and state or country) Canton, Missouri | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
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| 13a. FATHER'S NAME Robert Louis Lankford | 13b. MOTHER'S MAIDEN NAME Charlotte Dade | 14. NAME OF HUSBAND OR WIFE William Madison |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. None | 17. INFORMANT 110 South 22nd Street Mrs Charlotte M. Williams, City |
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| 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 8 days |
| IMMEDIATE CAUSE (a) Cerebral Thrombosis | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | |
| DUE TO (b) Arteriosclerosis Generalized | |
| DUE TO (c) | |

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| 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 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.) |
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| 20c. TIME OF INJURY Hour a.m. p.m. | Month, Day, Year |
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| 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 |
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21. I attended the deceased from 9-18-61 to 9-26-61 and last saw her alive on 9-26-61
Death occurred at 4:25 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) Iris Rosenthal M.D. | 22b. ADDRESS St Joseph Mo | 22c. DATE SIGNED (State) 9/29/61 |
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|--|---------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE Oct 7, 1961 | 23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery | 23d. LOCATION (City, town, or county) St. Joseph, Missouri |
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| 24. FUNERAL DIRECTOR Wm. H. DeFender | ADDRESS St. Joseph, Mo. | 25. DATE RECD. BY LOCAL REG. Oct. 4, 1961 | 26. REGISTRAR'S SIGNATURE Mrs Clark Goodell |
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INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

I. P. Rosenthal, M.D. 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 Wm. H. Alexander

Licensed Embalmer No. 4450

P. O. Address St. Joseph, 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.