

FILED MAY 11 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12548**
13448

Registration District No. **231**

Primary Registration District No. **4346**

Registrar's No. **10**

1. PLACE OF DEATH:

(a) County **Montgomery Co.**
(b) City or town **Montgomery City, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **/**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community **4 Weeks** years, months or days)

3. (a) PRINT FULL NAME **Marv Virginia Landrum.**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **James M. Landrum.** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Feb** **1st** **1857**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
91 **I** **6** hr. min.

9. Birthplace **Near New Florence, Mo.** (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Soloman Hart,**
13. Birthplace **Unknown Virginia.** (City, town, or county) (State or foreign country)
14. Maiden name **Mary Ann Candiff.**
15. Birthplace **Unknown Virginia.** (City, town, or county) (State or foreign country)

16. (a) Informant **Amy Badger**

(b) Address **Montgomery City, Mo.**

17. (a) **Burial** (b) Date thereof **March 10th 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Norman Cem.**

18. (a) Signature of funeral director **Norman Bates**

(b) Address **Americus, Mo.**

19. (a) **3-12-48** (b) **William J. Spires**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri.** (b) County **Montgomery Co.**
(c) City or town **New Florence, Mo. Rural** (If outside city or town limits, write "RURAL") **70**
(d) Street No. _____ (If rural, give location) **0**
(e) Citizen of foreign country? **No** (Yes or No) **0**
If yes, name country _____ **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **7th.**
year **1948** hour **7** minute _____ P.M.

21. I hereby certify that I attended the deceased from **2/24** 19 **48** to **3/7** 19 **48**

that I last saw her **PR** alive on **3/7** 19 **48** and that death occurred on the date and hour stated above.

Immediate cause of death **SENILITY** Duration _____

Due to **SENILE DEMENTIA.** **2 YEARS.**

INTERTROCHANTERIC FRACTURE OF RIGHT FEMUR 7 WEEKS AGO WITH SURGICAL REDUCTION AND FIX.
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____ PHYSICIAN _____

Of autopsy _____ **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury **2**

23. Signature **W. J. Wellman** (M. D. or other) _____

Address **Box 116 Montgomery City, Mo.** Date signed **3/8/48.**

WRITE PLAINLY—USE UNFADING-BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 5/10/48

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.....

....., **D. B. Baker,** Registered Apprentice No.....
working under my personal supervision.

Signed..... *D B Baker*.....

Licensed Embalmer No..... **3375**.....

P. O. Address..... **Americus, 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 this body is not embalmed, fact should be so stated above.

Registration District No. 231 Primary Registration District No. 4346

1. PLACE OF DEATH:
(a) County Montgomery
(b) City or town Montgomery City
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Mary D. Landrum
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Feb. 1 (Month) (Day) (Year)
8. AGE: Years 91 Months 1 Days _____ (If less than one day, hr. min.)

9. Birthplace _____ (City, town or county) (State or foreign country) Mo.

10. Usual occupation _____

11. Industry or business _____
12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Year 1948 Hour _____ Minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide (specify) Death was not due to external causes - fractured hip 3 months previous to death - in fall in private residence
(b) Date of occurrence _____
(c) Where did injury occur? _____ (Specify city or town)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

S-13448

1957
1958

1959
1960

1961
1962