JAN 25 1929

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

41928

1. PLACE OF DEATH

County: Osage — Registration District No. ____ — File No. ____

Township: Gasconade — Primary Registration District No. ____ — Registered No. ____

City ____ (No. ____, ____ St. ____ Ward)

2. FULL NAME Julia F. Lange

(a) Residence. No. ____ St., ____ Ward. ____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U.S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	

5a. If Married, Widowed, or Divorced — HUSBAND OF (OR) WIFE OF Fritz Lange

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2/23/1876

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
52	9	21	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer): ____

(c) Name of employer: ____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Osage Co. Mo.

PARENTS

10. NAME OF FATHER Louis Ocheskey

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Clara Gnadt

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

14. INFORMANT Fred Lange
(Address) Marvista Mo.

15. FILED ____, 19____ ____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/14 1928

17. I HEREBY CERTIFY, That I attended deceased from 12/14, 1928, to 12/14, 1928, that I last saw h. alive on 12/13, 1928 and that death occurred, on the date stated above, at 8:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebro Spinal meningitis

(duration) ____ yrs. ____ mos. 2 ds.

CONTRIBUTORY (SECONDARY) Influenza & Strepto C.

(duration) ____ yrs. ____ mos. 5 ds.

18. WHERE WAS DISEASE CONTRACTED: ____

IF NOT AT PLACE OF DEATH? ____

DID AN OPERATION PRECEDE DEATH? No. DATE OF ____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? ____

(Signed) Howard W. Lemon, M. D.
, 19 (Address) Pershing Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Friedens Cemetery — DATE OF BURIAL: 12-15 1928

20. UNDERTAKER: A. Hemmert — ADDRESS: Marvista Mo.

A.—Every item of information should be carefully applied. Write plainly. Use ink. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Osage — Registration District No. 639 — File No. .....

Township Benton — Primary Registration District No. 5848 — Registered No. .....

City ..... (No. ..... St. ..... Ward)

2. FULL NAME Julia F. Lange

(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
F	W	M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED 1-9, 1929 L. E. Souder
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/14 1928

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Epidemic
Meningococcus
Meningitis
D Hopkins

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) ....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

24

N. B.—[illegible] should be care[illegible] Exact statement of OCCUPA[illegible] important.
CAUSE [illegible] so that it ma[illegible]
REGISTRARS [illegible] RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-41928