

OCT 28 1930

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

85

 File No. 82128
 Registered No. 1104
 (Ward)

1. PLACE OF DEATH

County BuchananRegistration District No. 1001Township St. JosephPrimary Registration District No. 1001City St. Joseph(No. 1001 Wagon-Captain's Shop Ward)

2. FULL NAME

(a) Residence. No. Wagon Shop St. Wagon Shop Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

wid

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

Louise Langensack

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

Sept 7-

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

70028

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Domestic(b) General nature of industry, business, or establishment in which employed (or employer). Carpenter Shop(c) Name of employer Dr. Joz. St. Ry Co.

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

PARENTS

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

14. INFORMANT (Address)

Fred Langensack
St. Joseph, Mo.

15. FILED

1930John L. J. J.
REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Oct 5 1930

17.

I HEREBY CERTIFY, That I attended deceased from Sept14, 1930, to Oct 5, 1930, that I last saw him alive on Oct 4, 1930, and that death occurred, on the date stated above, at 12:30 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis9:3010:4(duration) 5 yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Hypertension(duration) unknown yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

NOT AT PLACE OF BIRTH

DID AN OPERATION PRECEDE DEATH? no DATE OF ✓WAS THERE AN AUTOPSY? noWHAT TEST CONFIRMED DIAGNOSIS? Clinical(Signed) Kirkpatrick, M. D.Oct 7, 1930 (Address) Kirkpatrick Bldg

*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

Oakland Cemetery10-7 1930

20. UNDERTAKER

ADDRESS

Flanagan Funeral Home 1946 Parkway

NOV 26 1941

100-100000

U. S. DEPARTMENT OF COMMERCE
BUREAU OF ECONOMIC WARFARE
OFFICE OF THE ASSISTANT SECRETARY FOR
ECONOMIC WARFARE
WASHINGTON, D. C.

**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 Rich-

Registration District No. 85

File No.

Township St. Joe

Primary Registration District No. 1001

Registered No. 1104

City St. Joe (No.)

St. Ward)

2. FULL NAME

(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 M 4. COLOR OF RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 7

7. AGE YEARS MONTHS DAYS If LESS than day, hrs. or min.
70 - 28

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)

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 10/7 30 John G. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 5 1930

17. I HEREBY CERTIFY That I attended deceased from 19....., 19....., and 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:

18. WHERE WAS DISEASE CONTRACTED (duration)..... yrs. mos. ds.
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)

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

REGISTRARS SHALL NOT RECEIVE A FEE FOR THIS SUPPLEMENTARY. EXACT STATEMENT OF OCCURRENCE IS VERY IMPORTANT. THIS STATE BOARD OF HEALTH SUPPLIES REGISTRATION FORMS TO ALL CITIES AND TOWNS IN MISSOURI. THESE FORMS SHOULD BE KEPT IN EACH CITY AND TOWN OFFICE. THE STATE BOARD OF HEALTH WILL BE RESPONSIBLE FOR THE CORRECTNESS OF THE INFORMATION ON THESE FORMS.

SUPPLEMENTARY

5-32/28

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