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

Do not use this space.

14001

1. PLACE OF DEATH
County Morgan Registration District No. 601
Township Richland Primary Registration District No. 5796
City (No. , St. Ward)

File No.
Registered No. 7

2. FULL NAME James Henry Langford
(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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): widowed

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF ~~(OR) WIFE OF~~ Lucy Smith

7. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 26 — 1858

AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	74	9	24	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lincoln Co. Mo
13. NAME Joshua Langford
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown
15. MAIDEN NAME Emma Palmer
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

INFORMANT Mrs. G. H. Worthley,
(ADDRESS) Florence, Mo.

17. BURIAL, CREMATION, OR REMOVAL
PLACE Folley, Mo. DATE 4-22, 1933
UNDERTAKER Rapp & son,
(ADDRESS) Stover, Mo.
FILED 4-26, 1933 Mrs. Edwin Bremer
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4 — 20, 1933

22. I HEREBY CERTIFY, That I attended deceased from 1 — 1, 1930, to 4 — 10, 1933
I last saw him alive on 4 — 18, 1933 Death is said to have occurred on the date stated above, at 11 P. m.
The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis

Date of onset

Other contributory causes of importance:
Chronic Int. Nephritis

Name of operation Date of
What test confirmed diagnosis? Symptoms Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur?
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home or public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) E. E. Holtgren, M. D.
(Address) Smithton, Mo.

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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No.....

City..... (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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)

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.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.....

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.....

10. Date deceased last worked at this occupation (month and year).....

11. Total time (years) spent in this occupation.....

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

FATHER

13. NAME

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

MOTHER

15. MAIDEN NAME

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

17. INFORMANT.....
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE..... DATE.....,19.....

19. UNDERTAKER.....
(ADDRESS)

20. FILED....., 19..... .....
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) ..... , 19

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to....., 19.....

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Other contributory causes of importance:	

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?.....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

.....

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed)....., M. D.

(Address).....

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.