

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

Do not use this space.

MAY 23 1935

1. PLACE OF DEATH

County Callaway
Township St. Charles
City St. Charles

Registration District No. 103
Primary Registration District No. 5154
(No. 103)

File No. _____
Registered No. 15
St. _____ Ward _____

12120

2. FULL NAME

(a) Residence, No. _____ St. _____ Ward _____
(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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, 6 hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. nil
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. nil
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) Mokane Mo RFD

FATHER 13. NAME Roy Langley

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Callaway Co Mo

MOTHER 15. MAIDEN NAME Mary Langley

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

17. INFORMANT (ADDRESS) Roy Langley

18. BURIAL, CREMATION, OR REMOVAL

PLACE Mokane DATE Apr. 11 1935

19. UNDERTAKER (ADDRESS) Glen W. Maupin Mokane Mo

20. FILED 4-12 1935 W. W. Williams Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-10 1935

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

I last saw her alive on _____, 19____. Death is said to have occurred on the date stated above, at 9:45 a.m.

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

Cardiac Insufficiency Date of onset _____

Other contributory causes of importance _____

Name of operation _____ Date of _____

What test confirmed diagnosis? Cerebral Was there an autopsy? yes

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? no
If so, specify _____

(Signed) R. G. Hall, M. D.

(Address) Fuller Mo

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.

