

NOV 16 1937

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

Do not use this space.

1. PLACE OF DEATH

County Cape Girardeau
Township _____
City Jackson, Mo (No. _____)

Registration District No. 124
Primary Registration District No. 4070

File No. 37324

Registered No. 44
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. Jackson, Mo 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

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 23 1937

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

22. I HEREBY CERTIFY, That I attended deceased from Oct 17 1937, to Oct 23 1937

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 14 1859

I last saw him alive on Oct 23 1937 Death is said to have occurred on the date stated above, at 7:30 a.m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
77 7 9

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

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

Chronic Gall Bladder Date of onset _____
NO malignancy

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

Other contributory causes of importance: Chronic Arteriosclerosis

13. NAME Unknown

Name of operation none Date of _____

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

What test confirmed diagnosis? specimen Was there an autopsy? no

15. MAIDEN NAME Langs

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____ 19 _____

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

Where did injury occur? _____ (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

17. INFORMANT (NAME AND ADDRESS) Mrs Otto Langs Jackson Mo R-7

Manner of injury _____

18. BURIAL, CREMATION, OR REMOVAL PLACE Lisle Lutheran Cemetery 10/25 1937

Nature of injury _____

19. UNDERTAKER (NAME AND ADDRESS) McConley Funeral Home Jackson Mo

24. Was disease or injury in any way related to occupation of deceased? no

20. FILED 10-25 37 D. G. Schmitt Registrar

If so, specify _____

(Signed) H. G. Schmitt M. D.

(Address) Jackson Mo

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

37324
Do not use this space.

1. PLACE OF DEATH

(a) County Cape Girardeau Registration District No. 124
 (b) Township Primary Registration District No. 4070 Registered No.
 (c) City Jackson (d) Street No. St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S. if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Wilhelmina Sprenger Lange

(a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR 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)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
77 7 9

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as 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. FUNERAL DIRECTOR (ADDRESS)

20. FILED 12-23 1937 B. G. Seiber
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 23 1937

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:

Chronic Gall Bladder
No Malnutrition
 Date of onset

Other contributory causes of importance:

Name of operation 127 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 High Cholesterol

(Signed) B. G. Seiber, M. D.

(Address) Jackson

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 Occupation of deceased in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

S-37324