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

REC'D NOV 21 1938

35749
Do not use this space.

1. PLACE OF DEATH
(a) County Greene — Registration District No. 321
(b) Township Clay — Primary Registration District No. 5444 — Registered No. 59
(c) City Rogersville, Rt. 1 — (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 81 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 593 Thomas H. Langston
(a) Residence, No. Rogersville, Mo. Rt. 1 St. [ ]
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, ~~OR DIVORCED~~ HUSBAND ~~OR (OR) WIFE OF~~ Mrs. Amanda Langston

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 16 - 1857

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
81	6	9	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired farmer
9. Industry or business in which work was done, as saw mill, bank, etc. & Stockman
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) Greene County, Mo.

FATHER
13. NAME Rev. Joseph W. Langston
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee

MOTHER
15. MAIDEN NAME Mary Cargile
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee

17. INFORMANT (ADDRESS) Frank Langston Rogersville, Mo. Rt. 1

18. BURIAL, CREMATION, OR REMOVAL
PLACE Hazelwood DATE Aug. 26, 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) B. G. Klepper Ozark, Mo.

20. FILED Nov. 8 1938 Mrs. Pearl Hughes Mitchell Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 25, 1938

22. I HEREBY CERTIFY, That I attended deceased from Aug. 17, 1938, to Aug 25, 19.....
I last saw him alive on Aug 25, 1938. Death is said to have occurred on the date stated above, at 11 a.m.
The principal cause of death and related causes of importance were as follows:

Carcinoma of Face of some years standing.
Paralysis Soft side Body due to Blood Clot in Brain

Date of onset

Other contributory causes of importance: 57

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? No

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 .....
29 (Signed) J. H. Walker, M. D.
(Address) Ozark Mo

(Licensed Embalmer's Statement on Reverse Side)

Chron... ...

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.

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, B. C. Klepper, or by Forest K. Klepper, Registered Apprentice No. 143, working under my personal supervision.

Signed B. C. Klepper

Licensed Embalmer No. M. 2178

P. O. Address Bark, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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1. PLACE OF DEATH
(a) County Greene — Registration District No. 321
(b) Township Clay — Primary Registration District No. 2444 — Registered No.
(c) City — (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 Thomas H Langston
(a) Residence, No. — St. [ ]
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: m
4. COLOR OR RACE: w
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): m

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

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

7. AGE: YEARS 81 — MONTHS 6 — DAYS 9 — If LESS than 1 day, ...hrs. or ....min.

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, 19 — *Local Registrar.*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 25, 1938

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:

Carcinoma of face of some years standing
Paralysis left side of body due to Blood Clot in Brain

Other contributory causes of importance:
Primary Seat of Malignancy was on right side of face

Date of onset: 52

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) J. H. Wade, M. D.
(Address) Ozark Mo

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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