

DEC'D FEB 20 1939

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

1406  
Do not use this space.

1. PLACE OF DEATH Jackson
- (a) County Kaw Registration District No. 399
- (b) Township Trinity Primary Registration District No. 1002 Registered No. 419
- (c) City Kansas City, Mo. (d) Street No. Trinity Lutheran Hospital, K.C.Mo. St. \_\_\_\_\_
- (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 Albert E. Lang,
- (a) Residence, No. 714 East Linwood, K.C.Mo. 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 <b>Male</b>	4. COLOR OR RACE <b>White</b>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <b>Married</b>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <b>Henrietta A. Lang.</b>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <b>Aug. 1 18 61</b>		
7. AGE YEARS <b>77</b>	MONTHS <b>5</b>	DAYS <b>28</b>
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. <b>Electrical Worker.</b>		
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) <b>Ohio</b>		
13. NAME <b>No Record</b>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <b>No Record</b>		
15. MAIDEN NAME <b>No Record</b>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <b>No Record.</b>		
17. INFORMANT <b>R.S. Townsend, 6003 Cherry Str.</b> (ADDRESS) <b>Kansas City, Missouri.</b>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <b>Green Lawn, Cem.</b> DATE <b>Jan. 31st, 1939</b>		
19. FUNERAL DIRECTOR (NAME) <b>Mrs. C.L. Forster</b> (ADDRESS) <b>918 Brooklyn Avenue, K.C.Mo.</b>		
20. FILED <b>Jan 31, 1939 M. H. Grome</b> Local Registrar.		

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) January 29, 1939.

22. I HEREBY CERTIFY, That I attended deceased from December, 1936, to Jan. 29<sup>th</sup>, 1939

I last saw him alive on Jan 29<sup>th</sup>, 1939. Death is said to have occurred on the date stated above, at 8:30 A.M.

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

Myocardial Failure.

Date of onset  
1-3-39.

Other contributory causes of importance:

Hypertension, Umbilical Hernia  
Chronic Sclerosis.  
Chronic Nephritis

Name of operation None. Date of \_\_\_\_\_

What test confirmed diagnosis? Chromal 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 \_\_\_\_\_  
 (Signed) Charles Forster, M. D.  
 (Address) 1103 Grand.

**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, \_\_\_\_\_, or by \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**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.**