

DEC 12 1939

## MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS,  
CERTIFICATE OF DEATH

8225

Do not use this space.

1990

## 1. PLACE OF DEATH

(a) County ..... Registration District No. **791**  
**1003**  
 (b) Township ..... Primary Registration District No. .... Registered No. ....  
 (c) City **St. Louis** (d) Street No. **St. Lukes Hospital** ..... 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 **525 Louise Anna Langenbach**

(a) Residence, No. **3650 a Botanical** St. **17** (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 **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Divorced**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **June 27, 1891**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
**67 8 1**

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Housewife**  
 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) **Feb 1939** 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis, Mo.**

FATHER 13. NAME **Anton Michel**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Alsace-Lorraine**

MOTHER 15. MAIDEN NAME **Bertha ~~KORFEN~~ Herrfurth**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Dresden Germany**

17. INFORMANT (ADDRESS) **Dr. Paul C. Langenbach 3650A Botanical**

18. BURIAL, CREMATION, OR REMOVAL PLACE **St. Matthews** DATE **3-4-** '39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Albert H. Hoppe Inc. 4700 Washington Blvd.**

20. FILE **MAR 2 1939** **J. D. B. Beck** (Local Registrar)

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Feb. 28**, 19**39**

22. I HEREBY CERTIFY, That I attended deceased from **Mar. 25**, 19**34**, to **Feb. 28**, 19**39**

I last saw her alive on **Feb. 28**, 19**39**. Death is said to have occurred on the date stated above, at **4 P. M.**

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

**Cerebral Haemorrhage (Pt.)** Date of onset **2-25-39**  
**Chronic myocarditis**  
**auricular fibrillation** **3-25-34**  
 Other contributory causes of importance: **Diabetes Mellitus** **3-25-34**

Name of operation **physical** Date of .....  
 What test confirmed diagnosis? **physical** 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 **Clouds Backe** M. D.

(Signed) **Clouds Backe** (Address) **3720 Washington**

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1130-65 1:30

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..... *Albert G. Hoff* .....

Licensed Embalmer No. 2971

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.