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.

REC'D JUN 12 1939

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

791
1003

16633
Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. ..... Registered No. 4167

(b) Township ..... Primary Registration District No. .....

(c) or City ST. LOUIS MO. (d) Street No. MISSOURI BAPTIST HOSP. 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.

521

2. PRINT FULL NAME HERBERT E. LANGFORD.

(a) Residence, No. SIKESTON MO. St. NR
(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 OF (OR) WIFE OF MURLE LANGFORD.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) FEBUARY 16TH 1895

7. AGE: YEARS 44 | MONTHS 2 | DAYS 17 | If LESS than 1 day, — hrs. or — min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. = LIFE =
9. Industry or business in which work was done, as saw mill, bank, etc. SUPT. OF INSURANCE Co.
10. Date deceased last worked at this occupation (month and year) APRIL 29TH
11. Total time (years) spent in this occupation 10 YRS.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) HICKMAN. KENTUCKY.

FATHER

13. NAME JOSESPH HENRY LANGFORD
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) CLARKSVILLE. TENNESSEE.

MOTHER

15. MAIDEN NAME NACY JANE OLIVER.
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) WHITE COUNTY ARKANSAS.

17. INFORMANT (ADDRESS) MURLE LANGFORD 219 DOROTHY, SIKESTON, MO

18. BURIAL, ~~CREMATION~~, OR REMOVAL PLACE HICKMAN KENTUCKY. DATE MAY 6TH 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) BROCKLAND UNDCO. 1827 HOGAN ST.

20. FILED MAY 4 1939 19 J. F. Bredeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) MAY 3RD 1939.

22. I HEREBY CERTIFY, That I attended deceased from 11/5, 1938, to 5/3, 1939
I last saw him alive on 5/3, 1939. Death is said to have occurred on the date stated above, at 7:15 P.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Portal cirrhosis	
Hypertension	
Duodenal ulcer	

Other contributory causes of importance:
hemorrhage from duodenal ulcer

Name of operation ..... Date of .....
What test confirmed diagnosis? clinical 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? .....
If so, specify .....
(Signed) Thomas C Bridgeman, M. D.
(Address) 4660 Maryland.

(Licensed Embalmer's Statement on Reverse Side)

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 Me

....., Registered Apprentice No.....

working under my personal supervision.

Signed John B. Brockland

Licensed Embalmer No. 93

P. O. Address St Louis Mo

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

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