

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9262
2745
Registrar's No.

Registration District No. 791 Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
City Hospital #1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 10 Hours
 In this community 13 Years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Ephram B. Langley
 3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 27, 1924
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>15</u>	<u>6</u>	<u>26</u>	hr. min.

9. Birthplace Maynard Arkansas
 (City, town, or county) (State or foreign country)

10. Usual occupation School Boy
 11. Industry or business School

MOTHER { 12. Name Ephram B. Langley Sr.
 18. Birthplace Kentucky
 (City, town, or county) (State or foreign country)
 14. Maiden name Lucy Brown
 15. Birthplace Kentucky
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Ephram B. Langley
 (b) Address 4246 A Norfolk
 17. (a) Burial (b) Date thereof 3/26/40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation New St. Marcus Cem.

18. (a) Signature of funeral director A. St. M. Langhlin
 (b) Address 2301 Lafayette

19. (a) MAR 25 1940 (Date received local registrar)
J. F. Bredon (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis 18
 (If outside city or town limits, write "RURAL")
 (d) Street No. 4246 A Norfolk
 (If rural, give location)
 (e) If foreign born, how long in this country _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 23
 year 1940 hour 11:30 minute 30 PM M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Mastoiditis
Acute Meningitis
J. M. B. Spindler
 Due to _____
 Due to _____

Other conditions (Include pregnancy within 3 months of death) 896

Major findings:
 Of operations _____
 Of autopsy _____

PHYSICIAN
 Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
 While at work? _____ (Specify type of place) _____ (Means of injury)

23. Signature Alfred Perry (M. D. or other)
 Address Mississippi Coronet Date signed 3-25-40

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

L. R. Cooper

Licensed Embalmer No.

3633

P. O. Address

2317 Lafayette

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.