

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

14763

Registration District No. 260

Primary Registration District No. 7169

Registrar's No.

1. PLACE OF DEATH:

(a) County DeKalb
 (b) City or town Osborn
 (c) Name of hospital or institution:
 (If outside city or town limits, write "RURAL" and name of township)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME Martha C. Langquary 526
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Widow
 6. (b) Name of husband or wife Benj. J. Langquary
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Oct 6 1864
 (Month) (Day) (Year)

8. AGE: Years 75 Months 4 Days 4
 If less than one day _____ hr. _____ min.

9. Birthplace DeKalb Co
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Samuel Coil

18. Birthplace Not known
 (City, town, or county) (State or foreign country)

14. Maiden name Sarah Sheratt

15. Birthplace Tennessee
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Reba Langquary

(b) Address Osborn, Mo

17. (a) Burial (b) Date thereof April 12 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Osborn

18. (a) Signature of funeral director Stewartsville Mo

(b) Address _____

19. (a) 4-12-40 (b) Mildred P. McMahon
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County DeKalb
 (c) City or town Osborn
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 10th
 year 1940 hour 12 M. minute _____ M.

21. I hereby certify that I attended the deceased from April 6th, 1940 to Apr 10th, 1940;
 that I last saw her alive on April 10th, 1940;
 and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy due to cerebral hemorrhage Duration 5 day

Due to high blood pressure

Due to _____

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

Major findings: _____

Of operations _____

Of autopsy _____

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?
235 (Specify type of place) (e) Means of injury _____

Signature L. E. Seward (M. D. or other) _____

Address Stewartsville Mo Date signed 4-11-40

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Rev. 5-17-39 I 11851

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.

RECEIVED
District Health Officer No. 111
District File Number 540-767
Date Filed MAY 16 1948

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 F. G. Ryan

Licensed Embalmer No. 952

P. O. Address Stewartville

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.