

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

25342

State File No. \_\_\_\_\_

Registrar's No. 190

Registration District No. 398

Primary Registration District No. 3019

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Independence  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
123 South Osage St.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 5 Years  
years, months or days)

3. (a) PRINT FULL NAME Adele Hawley Langton 523

8. (b) If veteran, name war No 8. (c) Social Security No. No

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Clell Langton 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Febr. 24 1868  
(Month) (Day) (Year)

8. AGE: Years 72 Months 5 Days 0 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Gallands Grove Iowa  
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business None

12. Name Gideon Hawley

13. Birthplace Montrose Iowa  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Hotcomb

15. Birthplace Bona Vista County Iowa  
(City, town, or county) (State or foreign country)

16. (a) Informant Nellie Martin

(b) Address 123 S. Osage

17. (a) Burial (b) Date thereof 7-26-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mound Grove

18. (a) Signature of funeral director Henry W. Stahl

(b) Address 815 W. Maple Ave.

19. (a) July 15 1940 (b) F. L. Cook  
(Date of local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Independence  
(If outside city or town limits, write "RURAL")  
(d) Street No. 123 South Osage St  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24  
year 1940 hour 6 minute 12 A M.

21. I hereby certify that I attended the deceased from July 22 1940 to July 23 1940  
that I last saw her alive on 11 PM July 23 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to vomiting + heat

Due to Diabetes mellitus

Other conditions Cardiovascular Disease  
(Include pregnancy within 3 months of death)

Major findings: Of operations 59

Of autopsy no

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? 3 to 5

(Specify type of place) While at work? \_\_\_\_\_ (a) Means of injury \_\_\_\_\_

23. Signature Ethel Watson (M.D. or other) \_\_\_\_\_

Address 409 First Natl Bldg Date signed 7/26/40

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

S. No. 2  
-11-10-39  
5-17-39  
PI X21492

8  
5  
4

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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 Henry W. Stahl  
Licensed Embalmer No. 3181  
P. O. Address Independence, Mo.

**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.**