

No. 2
-13-40
-17-39
X23193

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **43859**

JAN 8 1941
Registration District No. **784**

Primary Registration District No. **92**

Registrar's No. **2315**

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Normandy
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
7627 Natural Bridge Road
(If not in hospital or institution, write street number or location)
North of Grand Court Ave

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Emma Langan

3. (b) If veteran, name war _____

3. (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 John Langan

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec. 19, 1847.
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>92</u>	<u>11</u>	<u>18</u>	hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business _____

12. Name Prindable

13. Birthplace Don't Know
(City, town, or county) (State or foreign country)

14. Maiden name Don't Know

15. Birthplace Don't Know
(City, town, or county) (State or foreign country)

16. (a) Informant Rev. C.A. Prindable

(b) Address Krenrick Seminary

17. (a) removal (b) Date thereof Dec. 8/40.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chicago, Ill.

18. (a) Signature of funeral director Jos. W. Clark

(b) Address 1125 Hodiamont Ave.

19. (a) DEC 7 1940 (b) JK Meyers
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town Normandy
(If outside city or town limits, write "RURAL")

(d) Street No. 7626 Natural Bridge Road
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 7
year 1940 hour 1.15 minute P.M. M.

21. I hereby certify that I attended the deceased from Oct/1/1940
to 11/7/40, 19____, to _____, 19____;
that I last saw her alive on 11/7/40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Generalized Arterio Sclerosis, Myro-Carditis Chro-Int-Nephritis Senile - Dementia, Secondary Myro-Carditis -Decompensation Senile Dementia, Terminal, Uremia - (2 mo) Uremic Coma (4) days

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy None

Duration _____
Physician _____
Underline the cause to which death should be charged statistically.

22. If death was due to external cause, 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) (e) Means of injury

23. Signature Dr. Luke B. Finmonth (M. D. or other) _____
Address 3718 Jennings, Rd. Date signed _____

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

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Dr. L.B. Tiernon

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

Mark J. Tiernon

, Registered Apprentice No.

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working under my personal supervision.

Signed

[Signature]

Licensed Embalmer No. *3225*

P. O. Address *1125 Hodiament Ave*

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, fact should be so stated above.