

1. PLACE OF DEATH:

(a) County NEWTON
 (b) City or town NEOSHO, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
IN CAR ENROUTE TO HOSPITAL
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days)

3. (a) PRINT FULL NAME ROBERT LANGFORD

3. (b) If veteran, name war WORLD 3. (c) Social Security No. 511-10-0609

4. Sex MALE 5. Color or race White 6. (a) Single, widowed, married, divorced MARRIED
 6. (b) Name of husband or wife HANNAH LANGFORD 6. (c) Age of husband or wife if alive 51 years
 7. Birth date of deceased JAN 1 1893
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>48</u>		<u>26</u>	_____ hr. _____ min.

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

10. Usual occupation STEAM FITTER

11. Industry or business HARRY LFREYN CO - CAMP CROWDER

12. Name MELVIN LANGFORD
 13. Birthplace NOT KNOWN
 (City, town, or county) (State or foreign country)
 14. Maiden name MANNIE
 15. Birthplace NOT KNOWN
 (City, town, or county) (State or foreign country)

16. (a) Informant Dr. J. B. Thompson
 (b) Address PITTSBURG, KAN.

17. (a) REMOVAL (b) Date thereof JAN 27 1942
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation PITTSBURG, KANSAS

18. (a) Signature of funeral director J. B. Thompson

(b) Address NEOSHO, MISSOURI

19. (a) 1-27-42 (b) Osney Thompson
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State KANSAS (b) County CRAWFORD
 (c) City or town PITTSBURG
 (If outside city or town limits, write "RURAL")
 (d) Street No. 219 Adams
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 27
 year 1942 hour 6 minute 30 A.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 Died of Natural Cause, Probably Heart trouble. Duration _____
 Due to _____

Due to _____

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

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) (e) Means of injury 3

23. Signature J. P. Reynolds CORONER
 Address NEOSHO, MISSOURI Date signed 1/27/42

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

MOTHER FATHER

FEB 20 1942

RECEIVED

District Health Officer No. 6,

District File Number 242-243

Date Filed FEB 13 1942

DEC 29 1941

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 C. G. Stone Jr.

Licensed Embalmer No. 4176

P. O. Address Newark 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **3045**

Registration District No. **609**

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County **Newton**
(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
.....
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME **Robert Langford**

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **m**

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

7. Birth date of deceased **Jan 1**
(Month) (Day) (Year)

8. AGE: Years **48** Months Days If less than one day min

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b)..... (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits, write "RURAL")
(d) Street No..... (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** Day **1** Year **1942** Hour..... Minute..... M.

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

Immediate cause of death..... Duration

Heart trouble

Due to.....

Due to **D.M.O.**

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

Major findings: Of operations..... **95c2**

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?
..... (Specify type of place)

While at work?..... (c) Means of injury.....

23. Signature..... (M. D. or other)

Address..... Date signed.....

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

SUPPLEMENTARY

PHYSICIAN

Underline the cause to which death should be charged statistically.

MAY 14 1945