

S. No. 2
M-9-4-41
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 20 1942 791
Registration District No. **791**

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
Primary Registration District No. **1003**

19754
State File No. _____
Registrar's No. **5928**

006
17
1392
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis, Mo.**
(c) Name of hospital or institution:
Pronounced dead at City Hospital
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

3. (a) PRINT FULL NAME **Emil Langer**
3. (b) If veteran, name war **No**
3. (c) Social Security No. **NO**

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Anne**
6. (c) Age of husband or wife if alive **75** years
7. Birth date of deceased **Unknown**
(Month) (Day) (Year)

8. AGE: **abt 68**
Years Months Days If less than one day
hr. min.

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

10. Usual occupation **Caretaker**

11. Industry or business _____

MOTHER FATHER
12. Name **Unknown**
13. Birthplace **Do**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **do**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Anne Langer**
(b) Address **3920 Itaska St.**

17. (a) **Burial** (b) Date thereof **July 14, 1942**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **O. J. Hoffmeister**
(b) Address **4016 Chippewa St.**

19. (a) **JUL 13 1942** (b) **G. F. Bradack**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **000**
(a) State **Missouri** (b) County **17**
(c) City or town **3920 Itaska**
(If outside city or town limits, write "RURAL")
(d) Street No. **St. Louis, Mo.**
(If rural, give location)
(e) **No attending physician** (Yes or No)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **7** day **11**
year **1942** hour **12** minute **30 P.M.**
21. I hereby certify that I attended the deceased from _____
19____ to _____ 19____;
that I last saw h. _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Body Badly Decomposed
Lytic History
Due to _____
Due to _____
Other conditions (Include pregnancies within 3 months of death)
Major findings: Of operations **309**
Of autopsy **34**
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 **[Signature]** (M. D. or other) **3**
Address _____ Date signed **7/13/42**

(Licensed Embalmer's Statement on Reverse Side)

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.....

W. C. Embalming
Ernest W. Spill
Licensed Embalmer No.....
P. O. Address *License # 4086*

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.