

S. No. 2
M-9-4-41
Py. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **24983**

FILED AUG 9 1943
Registration District No. **128**

Primary Registration District No. **2000**

Registrar's No. **5567**

1. PLACE OF DEATH: **GREENE**

(a) County **GREENE**

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

(c) Name of hospital or institution: **Burge 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..... (Specify whether)

years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene**

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

(d) Street No. **700 S. Hampton**
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME **Agnes Silsby Langston**

3. (b) If veteran, name war **None**

3. (c) Social Security No. **None**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **9** year **1943** hour **9** minute **43** A.M.

21. I hereby certify that I attended the deceased from **July 9, 1943** to **July 9, 1943**

that I last saw her alive on **July 9, 1943** and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Walter Langston**

6. (c) Age of husband or wife if alive **17** years (Day) (Year)

7. Birth date of deceased **October 17 1888**
(Month) (Day) (Year)

Immediate cause of death

Hyperthyroid crisis 3dy

Due to **hypoductomy for hyperthyroidism** 3dy

Due to.....

Other conditions (Include pregnancy within 3 months of death)

8. AGE: Years **54** Months **8** Days **22** If less than one day hr. min.

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

10. Usual occupation **House Wife**

Major findings: **Recurrent toxic goiter**

Of operations **63**

Of autopsy.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

11. Industry or business.....

12. Name **J. W. Silsby**

13. Birthplace **England** **Unk.** **Erg. 4**
(City, town, or county) (State or foreign country)

14. Maiden name **Ida Dörner**

15. Birthplace **Missouri** **Unk.** **Mo. 0**
(City, town, or county) (State or foreign country)

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?.....

23. Signature **W. M. D. Guber** (M. D. or other) **7/24/43**
Address **Red Oak Sp. 47** Date signed **7/24/43**

16. (a) Informant **Walter W. Langston**

(b) Address **700 S. Hampton**

17. (a) **Burial** (Burial, cremation, or removal)

(b) Date thereof **July 13 1943** (Month) (Day) (Year)

(c) Place: burial or cremation **Hazelwood**

18. (a) Signature of funeral director **Alma Lohmeyer** Funeral Home

(b) Address **534 St. Louis Springfield, Mo.**

19. (a) **7-23-43** (Data received local registrar)

(b) **W. M. D. Guber** (Registrar's signature)

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

39
2
6

434

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..... *Ed W. May*
Licensed Embalmer No. *1767*
P. O. Address. *Springfield*

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.

X