

No. 2
-5-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16517
State File No. _____
Registrar's No. **4608**

FILED MAY 25 1944
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis mo

(b) City or town St. Louis mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution? DeSloge Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 days
(Specify whether in this community years, months or days) life

3. (a) PRINT FULL NAME Langer, Annie

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex F **5. Color or race** W

6. (a) Single, widowed, married, divorced 2

6. (b) Name of husband or wife Emily

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

7. Birth date of deceased July 19 1868
(Month) (Day) (Year)

8. AGE: Years 75 Months 9 Days 27 If less than one day, hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business Patrick Walsh

12. Name Patrick Walsh

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

14. Maiden name Mary Mc Swiney

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

16. (a) Informant Margaret Burke

(b) Address 3609^{1/2} Montana

17. (a) Burial, cremation, or removal Burial **(b) Date thereof** 5/19/44
(Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Oscar J Hoffmeister

(b) Address 4016 Chipperwood

19. (a) Date received for local registration MAY 18 1944 **(b) Registrar's signature** J. D. Breda

2. USUAL RESIDENCE OF DECEASED:

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

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 2920 Alaska
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 16
year 44 hour 8 minute 05 P. M.

21. I hereby certify that I attended the deceased from 4-24
1944 to 5-16 1944

that I last saw h. er alive on 5-16 1944
and that death occurred on the date and hour stated above.

Immediate cause of death abdominal ulcer perforation, malignant lymphoma, carcinoma of gall bladder & secondary carcinoma of liver

Due to _____

Due to _____

Other conditions cholelithiasis, tumor up adrenal (lymphoma) NA erosive

Major findings generalized lymph adenopathy, cholecystitis, carcinoma of adrenal glands, lymphadenitis, cholelithiasis, erosive

Physician _____

Underline the cause to which death should be charged statistically.

21. 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 _____

Signature Philip T. Gray (M. D. or other) _____

Address 1325 So. Stuart Date signed 5-17-44

89K

MAY 18 1951

Embalmer's Separate Certificate filed

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.....

Licensed Embalmer No.....

P. O. Address.....

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.