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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED DEC 30 1944

Registration District No. _____

Primary Registration District No. 3063

Registrar's No. 2365

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
(Specify whether
In this community life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis 96
(c) City or town Gardenview 0
(If outside city or town limits, write "RURAL")
(d) Street No. 4959 Hummelshelms 0
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Rosa Langa

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife Frank Langa 6. (c) Age of husband or wife if alive 17 years
7. Birth date of deceased October 17 1902
(Month) (Day) (Year)

8. AGE: Years 42 Months 1 Days 11 If less than one day hr. _____ min. _____

9. Birthplace St. Louis County Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business _____

12. Name Gustave Voigt
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Amalia Gass
15. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Amalia Voigt
(b) Address 4959 Hummelshelms

17. (a) Burial (b) Date thereof Dec 1, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Sunset Burial Park

18. (a) Signature of funeral director J. L. Ziegenhein & Sons
(b) Address 7027 Gravois Ave.

19. (a) DEC 1 1944 (b) E. J. Maschurant
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 28
year 1944 hour 3 minute 0 M.

21. I hereby certify that I attended the deceased from 11 - 24 1944 to 11 - 28 1944
that I last saw him alive on 11 - 28 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinomatosis Generalized
Due to _____
Due to 55e
Other conditions (Include pregnancy within 3 months of death) _____

Duration

PHYSICIAN

Major findings: Of operations _____
Of autopsy none done
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) (c) Means of injury _____
Signature John Niedermeier (M. D. or other) MD
Address 661 Bismarck Blvd Date signed 11/28/44

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

MOTHER FATHER

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.....

B. P. Kidwell

Licensed Embalmer No. *3877*

P. O. Address *7027 Gravois*

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.