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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. **37389**

**FILED DEC 10 1945**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Howell

(b) City or town Rural - Simm Valley Twp.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Home  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 27 Years.  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell

(c) City or town Rural - Simm Valley Twps.  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME CHARLES HENRY LANGDON

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Married

6. (b) Name of husband or wife Effie Frazee Langdon 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Aug. 21, 1869  
(Month) (Day) (Year)

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

76 3 2 hr. \_\_\_\_\_ min.

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Ransom H. Langdon

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

14. Maiden name P. oebe Ann Quick

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

16. (a) Informant H. J. Langdon

(b) Address Mtn. View, Mo. R.R. #1.

17. (a) Burial (b) Date thereof 11-25-45.  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Willow Spgs. Cemetery

18. (a) Signature of funeral director Burns Funeral Home,

(b) Address Willow Springs, Missouri.

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 23  
year 1945 hour 2:29 minute P. M.

21. I hereby certify that I attended the deceased from 11-9-45  
\_\_\_\_\_ 19\_\_\_\_, to 11-23-45  
\_\_\_\_\_ 19\_\_\_\_

that I last saw him alive on 11-9-45  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis Duration 2wks

Due to Arteriosclerosis 10yrs

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? \_\_\_\_\_

(Specify type of place)  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or \_\_\_\_\_)

Address Willow Springs, MO. Date signed 11-27-45

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

7-1457

(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.....

.....  
working under my personal supervision.

..... Registered Apprentice No. ....

Signed *Thomas P. Burns*.....

Licensed Embalmer No. 4214.....

P. O. Address Willow Springs, Missouri.....

**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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. (143)

Primary Registration District No. (5560)

Registrar's No. 51

1. PLACE OF DEATH:

(a) County Hairell

(b) City or town Rural (Willow Springs, Mo)  
(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 years, months or days)

In this community \_\_\_\_\_  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Hairell

(c) City or town Rural  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME Charles H. Langdon

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex m

5. Color or race ww

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

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Aug 2  
(Month) (Day) (Year)

8. AGE: Years 76 Months 3 Days \_\_\_\_\_  
(If less than one day, hr. min.)

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER

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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) Tha memillen  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_  
year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

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