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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. **41286**
Registrar's No. **6**

FILED JAN 8 1945
Registration District No. **206**

Primary Registration District No. **574**

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

1. PLACE OF DEATH:

(a) County Madison

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

(c) Name of hospital or institution: 10

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. About 9 yrs. (Specify whether years, months or days)

In this community About 9 yrs.

3. (a) PRINT FULL NAME JOHN WALTER LANGLEY

3. (b) If veteran, name war World War II

3. (c) Social Security No. _____

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced (1)

6. (b) Name of husband or wife. _____

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

7. Birth date of deceased. Dec. 29 1922
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>22</u>	<u>11</u>	<u>24</u>	hr. _____ min.

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

10. Usual occupation armed forces.

MOTHER FATHER

11. Industry or business _____

12. Name Chas Langley

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

14. Maiden name Mella
(City, town, or county) (State or foreign country)

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

16. (a) Informant Heleen Elders

(b) Address Fidestown Mo

17. (a) burial (b) Date thereof 1/26/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Masonic, Fidestown

18. (a) Signature of funeral director W. H. Hines

(b) Address Madison Mo

19. (a) 12-26-45 (b) Florence Hines
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Madison

(c) City or town Marysland (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 23
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 12-23-45 to _____, 19____
that I last saw him alive _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Broken neck Immediate

Due to Truck ran off of road.

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: 1704
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) accident

(b) Date of occurrence 12-23-45

(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? Warehouse, Transp. Station
While at work? no (Specify type of place) (e) Means of injury Truck accident

23. Signature W. H. Hines (M. D. or other)

Address Fidestown Mo Date signed 12-28-45

RECEIVED

District Health Officer No. 4

District File Number 146-1471

Date Filed 1-5-46

JAN 23 1946

APR 9 1946

OCT 8 1946

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 *John Helt*

Licensed Embalmer No. 4264

P. O. Address *Fredericktown MD*

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. Jan
Registrar's No. 84

Registration District No. 206

Primary Registration District No. 5743

1. PLACE OF DEATH:

(a) County Madison
(b) City or town Rural
(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 _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME

John W. Langley

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec 29, 1922
(Month) (Day) (Year)

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

9. Birthplace _____ (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) Frederic Hicks
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19 _____;
that I last saw him/her 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)
Major findings:
Of operations _____
Of autopsy _____

Duration _____
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) (e) Means of injury _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

APR 9

1945

OCT 8 1945

41786