

**FILED FEB 8 1946**

Registration District No. **82**

Primary Registration District No. **3017**

Registrar's No. **5**

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

**1. PLACE OF DEATH:**  
 (a) County **Cooper**  
 (b) City or town **Boonville**  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: **St. Joseph's Hospital**  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **3 Months**  
(Specify whether years, months or days)  
 In this community **40 Years**

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State **Missouri** (b) County **Cooper**  
 (c) City or town **Boonville**  
(If outside city or town limits, write "RURAL")  
 (d) Street No. **510 Third St**  
(If rural, give location)  
 (e) Citizen of foreign country? **No**  
(Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME Mrs Minnie Langlotz**  
 (b) If veteran, name war **None**  
 (c) Social Security No. **None**

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month **January** day **19th**  
 year **1946** hour **11:30** minute \_\_\_\_\_ a **M.**  
**21. I hereby certify that I attended the deceased from** **Dec 1**  
 19**45**, to **Jan 19**, 19**46**;  
 that I last saw her alive on **Jan 18**, 19**46**;  
 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 **Widowed**  
 (b) Name of husband or wife **John Langlotz** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased **December 18** **1869**  
(Month) (Day) (Year)

Immediate cause of death **Septic**  
 Due to **Bed sore**  
 Due to **Fracture left leg**  
 Other condition **Diabetes, Arteriosclerosis**  
(Include pregnancy within 3 months of death)  
 Duration **2-3 wks.**

8. AGE: Years **76** Months **1** Days **0**  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_  
 9. Birthplace **Cooper County Missouri**  
(City, town, or county) (State or foreign country)  
 10. Usual occupation **Housewife**

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**  
**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.

11. Industry or business **Home**  
**12. Name John Schubert**  
**13. Birthplace Germany**  
(City, town, or county) (State or foreign country)  
**14. Maiden name Unknown**  
**15. Birthplace**  
(City, town, or county) (State or foreign country)

**16. (a) Informant Miss Marie Langlotz**  
**(b) Address Boonville, Mo.**  
**17. (a) Burial (b) Date thereof 1/22/46**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
**(c) Place: burial or cremation Walnut Grove Cem.**  
**18. (a) Signature of funeral director Stegner & Koenig**  
**(b) Address Boonville, Mo.**  
**19. (a) 1-21-46 (b) Clay Marie**  
(Date received local registrar) (Registrar's signature)

**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 Dr. L. Dieckmann (M. D. or other) M.D.**  
**Address Boonville Mo** Date signed **1/21/46**

RECEIVED

District Health Officer No. 8,

District File Number -----

Date Filed 2-7-46

MAR 21 1947

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 James W. Segner

Licensed Embalmer No. 3780

P. O. Address Boonville, Mo.

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. 106  
Registrar's No. 1

Registration District No. 82 Primary Registration District No. 3017

1. PLACE OF DEATH:  
(a) County Cooper  
(b) City or town Boonville  
(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 \_\_\_\_\_ years, months or days

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 \_\_\_\_\_

3. (a) PRINT FULL NAME Minnie Langlet  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month \_\_\_\_\_ Year 1946 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_ give \_\_\_\_\_ years

7. Birth date of deceased Dec 1 1888  
(Month) (Day) (Year)  
8. AGE: Years 76 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Mo  
(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 \_\_\_\_\_ (City, town, or county) (State or foreign country)

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) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

Due to \_\_\_\_\_  
Due to Fracture left femur  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_  
Duration \_\_\_\_\_

**SUPPLEMENTARY**

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) To be 14-19 45  
(b) Date of occurrence 10/14/45 To Name  
(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? Home  
While at work? Yes (Specify type of place) (e) Means of injury fall  
23. Signature M. K. Decker (M. D. or other) MD  
Address Boonville Mo Date signed 2/12/46

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

MAR 24 1947

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