DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 10 1947

Registration District No. 176

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1443

Primary Registration District No. 3026

Registrar's No. 19

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Independence
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 210 S. Main
(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: 35 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson
(c) City or town: Independence
(If outside city or town limits, write "RURAL")
(d) Street No.: 220 S. Liberty
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: MARY ANN LANGDON
3. (b) If veteran, name war: none
3. (c) Social Security No.:
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: divorced
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: Sept. 17, 1870 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
76	4	4	hr. min.

9. Birthplace: Marsfield (City, town, or county) Mo. (State or foreign country)
10. Usual occupation: Housework
11. Industry or business:
FATHER 12. Name: Thomas Stone
13. Birthplace: Tenn. (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Ledgeworth
15. Birthplace: (City, town, or county) (State or foreign country)
16. (a) Informant: Julia B. Langdon
(b) Address: Independence, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1/24/47 (Month) (Day) (Year)
(c) Place: burial or cremation: Woodlawn Cemetery
18. (a) Signature of funeral director: Geo. C. Carson
(b) Address: Independence, Mo.
19. (a) 1-30-47 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 21 year 47 hour minute M.
21. I hereby certify that I attended the deceased from Dec 7, 1946 to Jan 21, 1947 that I last saw h. alive on 21 Jan 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Myocardial failure	3
Auricular fibrillation	?
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations: 95 P
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: (M. D. or other) MD
Address: Date signed 1-21-49

(Licensed Embalmer's Statement on Reverse Side)

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

FEB 19 1942

OCT 22 1942

JUN 4 1948

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 Pasley

Licensed Embalmer No. 4308

P. O. Address Independence, I

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

2B
-45
43880

WRITE PLAINLY—USE UNFADING BLACK INK—MA[illegible]ERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Tut

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 19

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Independence
(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 Mary A. Langdon

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept 17 (Month) (Day) 1878 (Year)

8. AGE: Years 76 Months 4 Days 12 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant Jollie R. Langdon

(b) Address 308 So. Liberty Indep. Mo.

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Jan day 21 year 1947 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

S-1443