

FILED MAR 26 1947
Registration District No. **4**

Primary Registration District No. **3072**

Registrar's No. **46**

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

1. PLACE OF DEATH:
(a) County **SALINE**
(b) City or town **MARSHALL**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **FITZGERALDS**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **6 DA**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **FLORENCE NETTIE LANGE**
3. (b) If veteran, name war **✓** **3. (c) Social Security** No. **—**

4. Sex **FEMALE** **5. Color or race** **WHITE** **6. (a) Single, widowed, married,** divorced **MARRIED**
6. (b) Name of husband or wife. **6. (c) Age of husband or wife if** **JOHN LANGE** **alive** **55** **years**
7. Birth date of deceased. **APR. 4, 1898**
(Month) (Day) (Year)

8. AGE: Years **48** Months **10** Days **18** If less than one day hr. min.

9. Birthplace **EDMONDS CO KY 1**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSE WIFE**

11. Industry or business **AT HOME**

MOTHER FATHER
12. Name **HARVEY THOS. STEPHENS**
13. Birthplace **KY 1**
14. Maiden name **LOUISE LANCASTER**
15. Birthplace **KY 1**
(City, town, or county) (State or foreign country)

16. (a) Informant **John Lange**

(b) Address **Summit Spring Mo**
17. (a) Burial (b) Date thereof **2/19/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **FAIRVIEW CEMETERY**

18. (a) Signature of funeral director **R. C. Carter**

(b) Address **Summit Spring Mo**

19. (a) Feb 27 1947 (b) **W. H. Gray**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **SALINE**
(c) City or town **SWEET SPRING MO**
(If outside city or town limits, write "RURAL")
(d) Street No. **LOUGST ST**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or, No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **FEB** day **26** year **1947** hour **11** minute **15 A** M.

21. I hereby certify that I attended the deceased from **July 19**, 1947, to **July 26**, 1947;
that I last saw her alive on **July 26**, 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death: **Pulmonary embolus** **12 hrs**

Due to **Hysterectomy 2-20-47**

Due to **Uterine fibroids**

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

Major findings: **Fibroid uterus**
Of operations
Of autopsy **56**

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 **W. H. Gray** (M. D. or other)
Address **Marshall Mo** **Date signed** **2/27/47**

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 3-26-47

APR 10 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 [Signature]

Licensed Embalmer No. 3513

P. O. Address [Signature]

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.