FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35975

Registration District No. FILED OCT 24 1948

Primary Registration District No. 1003

Registrar's No. [illegible]

1. PLACE OF DEATH:

(a) County

(b) City or town ST. LOUIS (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1560A S 7th St (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000

(c) City or town ST. LOUIS (If outside city or town limits, write "RURAL") 17

(d) Street No. 1304 S. 3rd St. (If rural, give location) 9

(e) ~~Citizen~~ 23 of foreign country? (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME REV. ELIZABETH LANHAM

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex FEM.

5. Color or race W.

6. (a) ~~Single, widowed~~, married, ~~divorced~~ MARRIED

6. (b) Name of husband or wife ORVILLE J. LANHAM

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

7. Birth date of deceased MAY (Month) 29 (Day) 1889 (Year)

8. AGE: Years 58 Months 4 Days 5 If less than one day hr. min.

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

10. Usual occupation PENTECOST REV.

11. Industry or business PENTECOST Church.

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

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

16. (a) Informant Mr. Orville J. Lanham

(b) Address 1304 S. 3rd St.

17. (a) BURIAL (Burial, ~~cremation, or removal~~) (b) Date thereof Oct 8-47 (Month) (Day) (Year)

(c) Place: burial ~~or cremation~~ ST. MATTHEWS.

18. (a) Signature of funeral director E. J. Schnur

(b) Address 3125 Lafayette Av.

19. (a) OCT 7 1947 (Date received local registrar) (b) D. F. Bredrick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 4 year 1947 hour 9 minute 50 p.M.

21. I hereby certify that I attended the deceased from October 3rd, 1947, to 19 ; that I last saw her alive on October 4th, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic myocarditis	
Due to	
Due to	
Other conditions: Bronchical Asthma (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause of 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 other) M.D.

Address 1319 So. Bdwy-St. Louis, 4, Mo. Date signed 10-6-47

Jefferson City Printing Co. (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.....

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

working under my personal supervision.

Signed.....

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette

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.**

2B
45
43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. N 02

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9280

1. PLACE OF DEATH:

(a) County
(b) City or town St. LOUIS
(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

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 Elizabeth Lanham

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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased May 29 1888 (Month) (Day) (Year)

8. AGE: Years 58 Months 4 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Indiana (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
(b) Address

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) 10-7-47 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

NOV 3 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October 4 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.

Immediate cause of death — Duration

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-35975