

FILED JUL 5 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20722
Registrar's No. 38

BIRTH NO. _____ REG. DIST. NO. 159 PRIMARY REG. DIST. NO. 4249

0500
4

1. PLACE OF DEATH a. COUNTY Jefferson,		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri COUNTY St. Francois	
b. CITY (If outside corporate limits, write RURAL and give township) OR Hillsboro		c. CITY (If outside corporate limits, write RURAL and give township) OR Libertyville	
c. LENGTH OF STAY (In this place) 6 days		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Cedar Grove Nursinghome			

3. NAME OF DECEASED a. (First) Mary		b. (Middle) L.		c. (Last) Langford		4. DATE OF DEATH (Month) (Day) (Year) June/ 25/ 50	
5. SEX Female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Jan/9/1874	
9. AGE (In years last birthday) 74		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Ste Genevieve Co., Mo.		12. CITIZEN OF WHAT COUNTRY America	

13a. FATHER'S NAME A.H. Chadwell		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Robert J. Langford	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Jesse Coleman Farmington #3, Mo.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 2 weeks
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Cerebral Vascular Disease		
	DUE TO (c) None		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 445X			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 6-21, 1950, to 6-21, 1950, that I last saw the deceased alive on 6-21-50, and that death occurred at 12:15 pm., from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title)		23b. ADDRESS Farmington Mo		23c. DATE SIGNED 6-21-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6/26/50		24c. NAME OF CEMETERY OR CREMATORY Valle Springs	
				24d. LOCATION (City, town, or county) (State) Ste, Genevieve Mo.	

DATE REC'D BY LOCAL REG. 6-25-50		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Cozean Funeral Home, Farmington, Mo.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JEFFERSON COUNTY HEALTH DEPT.
HILLSBORO, MISSOURI
DATE RECEIVED 7-1-50

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed C. H. Cozari

Licensed Embalmer No. 4084

P. O. Address Farmington, 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.