

FILED JUN 29 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21980

State File No. 5410

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. 1003		Registrar's No. 5410			
1. PLACE OF DEATH a. COUNTY 318				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo.				b. COUNTY	
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		9069			
d. FULL NAME OF HOSPITAL OR INSTITUTION 1416 Rowan Ave.				d. STREET ADDRESS (If rural, give location) 1416 Rowan Ave.				0	
3. NAME OF DECEASED a. (First) ROSE			b. (Middle)			c. (Last) SCHLANGEN			
4. DATE OF DEATH		June 19 1950		5. SEX Female		6. COLOR OR RACE White			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH Dec. 17, 1874		9. AGE (In years last birthday) 75		10. MONTHS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY?			
13a. FATHER'S NAME Jacob Runder			13b. MOTHER'S MAIDEN NAME Elizabeth Minges			14. NAME OF HUSBAND OR WIFE Late John M. Schlangen			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Martin Schlangen 4527a San Francisco					
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, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <i>Arteriosclerosis of the brain</i> INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i>					
				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE <input type="radio"/> (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? <i>H200</i>					
22. I hereby certify that I attended the deceased from <i>9/4, 1926</i> , to <i>6/19, 1950</i> , that I last saw the deceased alive on <i>6/18, 1950</i> , and that death occurred at <i>3:00A m.</i> , from the causes and on the date stated above.									
23a. SIGNATURE <i>M. E. Luff M.D.</i>				23b. ADDRESS <i>634 No Grand</i>		23c. DATE SIGNED <i>6/20/50</i>			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE June 22, 50		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.			
DATE REC'D BY LOCAL REG. <i>6/20 1950</i>		REGISTRAR'S SIGNATURE <i>J. B. Laster</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Kriegshauser 4228 S. Kingshighway Bl.</i>					

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

Ms. Medicine 1 day 1-1

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 _____

working under my personal supervision.

Student Embalmer No.

Signed Richard W. Stovesand

Signed
Student Embalmer

Licensed Embalmer No. 4007

P. O. Address

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.