No. 300
10.48

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

FILED AUG 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28391
Registrar's No. 6887

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis
c. LENGTH OF STAY (in this place): 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Alexian Bros. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis 2029
d. STREET ADDRESS (If rural, give location): 5329 Quincy 0

3. NAME OF DECEASED (Type or Print)
a. (First): George
b. (Middle): A
c. (Last): Lang

4. DATE OF DEATH (Month) (Day) (Year): Aug. 11, 1950

5. SEX: male 0
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: June 28, 1880
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Public Relations
10b. KIND OF BUSINESS OR INDUSTRY: Mercantile Bus.
11. BIRTHPLACE (State or foreign country): Highland, Ill.
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Robert Lang
13b. MOTHER'S MAIDEN NAME: Emma Schwarz
14. NAME OF HUSBAND OR WIFE: Emma Lang

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.: 489-07-2134
17. INFORMANT'S SIGNATURE OR NAME: Emma Lang — ADDRESS: 5329 Quincy

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Left Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 9 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

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 ☒ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 490X

22. *I hereby certify that I attended the deceased from* Aug 4, 1950, *to* Aug 11, 1950, *that I last saw the deceased alive on* Aug 11, 1950, *and that death occurred at* 9 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): A. L. Hertel M.D.
23b. ADDRESS: 3606 Gravois
23c. DATE SIGNED: 8/12/50

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/14/50
24c. NAME OF CEMETERY OR CREMATORY: St Paul Churchyard
24d. LOCATION (City, town, or county) (State): St Louis County, Mo.

DATE REC'D BY LOCAL REG.: AUG 14 1950
REGISTRAR'S SIGNATURE: J. B. Sabater
25. FUNERAL DIRECTOR'S SIGNATURE: J L Ziegenhein & Sons — ADDRESS: 7027 Gravois

(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.....

.....,

working under my personal supervision.

Student Embalmer No.....

Signed Frank J. Owens

Signed.....
Student Embalmer

Licensed Embalmer No. 2245

P. O. Address St Louis Mo.

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

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