

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39308**
Registrar's No. **10550**

FILED DEC 8-1951

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (In this place) Lifetime		d. STREET ADDRESS (If rural, give location) 6107 Gravois Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Louise b. (Middle) c. (Last) Lange			4. DATE OF DEATH (Month) (Day) (Year) Nov. 25, 1951			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 4, 1876	9. AGE (In years last birthday) 75	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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) St. Louis, MO.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Peter Schubert		13b. MOTHER'S MAIDEN NAME Louisa Suedmeyer		14. NAME OF HUSBAND OR WIFE Henry Lange	
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 Henry Lange 6107 Gravois Ave.	

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* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Hypertensive C.V. disease 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.			INTERVAL BETWEEN ONSET AND DEATH 24 hours 7-10 Years
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 443X	

22. I hereby certify that I attended the deceased from **2 Nov. 1951**, to **25 Nov. 1951**, that I last saw the deceased alive on **25 Nov. 1951**, and that death occurred at **5:53 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) R. H. Schmeisser M.D.		23b. ADDRESS 6817^o Gravois Ave.		23c. DATE SIGNED 25 Nov 51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 11-28-51		24c. NAME OF CEMETERY OR CREMATORY Concordia Cemetery	
DATE REC'D BY LOCAL REG. NOV 27 1951		REGISTRAR'S SIGNATURE J. Earl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS SUEDMEYER & SON'S 3934 N. 20 Street	

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

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

Gustav W. Dittale

Licensed Embalmer

P. O. Address

*4329
St. Louis, 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.