

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15549**

FILED APR 29 1957

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 541 Registrar's No. 923

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri		b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clayton		c. CITY OR TOWN Maplewood		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. LENGTH OF STAY (in this place) 5 days		e. STREET ADDRESS (If rural, give location) 7731 Jerome Ave.			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis County Hospital					

3. NAME OF DECEASED (Type or Print) JAMES P. LANGFORD			4. DATE OF DEATH (Month) (Day) (Year) April 5 1957		
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH 4-9-1869		9. AGE (In years last birthday) 87
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	11. BIRTHPLACE (City and State or Foreign Country) Lemay, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Charles Langford		13b. MOTHER'S MAIDEN NAME Margaret Lynch		14. NAME OF HUSBAND/OR WIFE None	
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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 Ann Langford, above			ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		DUE TO (b) _____				
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		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? 2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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?	

22. I hereby certify that I attended the deceased from 3-31-, 1957, to 4-5-, 1957, that I last saw the deceased alive on 4-5-, 1957, and that death occurred at 6:20 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Joseph P. Ernst MD		23b. ADDRESS 601 S. Brentwood Clayton, Mo.		23c. DATE SIGNED 4-5-1957	
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 4-8-1957	24c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
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DATE REC'D BY LOCAL REG. 4-7-57		REGISTRAR'S SIGNATURE Herbert B. Donahoe		25. FUNERAL DIRECTOR'S SIGNATURE JAY B. SMITH, Maplewood, Mo.		ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

S. No. 300
V. 10.48

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.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 402

P. O. Address Maplewood

**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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.**