

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-027151  
STATE FILE NUMBER

6804  
REGISTRAR'S NO.

Registration District No. **318** Primary Registration District No. **1003**

FILED JUL 18 1958

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S. 300  
1-57

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>St. Louis</b>  |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN <b>St. Louis</b>                                  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Chronic Hospital</b>  |                                  | Length of stay in 1b   | d. STREET ADDRESS <b>5800 Arsenal</b> (If outside, give location) |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Emma</b> Middle <b>Juliana</b> Last <b>Langston</b>   |                                  | 4. DATE OF DEATH<br>Month <b>7</b> - Day <b>7</b> - Year <b>1958</b>   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>11-25-1878</b>                             |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Nil</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Nil</b>  | 9. AGE (In years (birthday))<br><b>79</b>                         |
| 11. BIRTHPLACE (City and state or country)<br><b>Wittenburg, Mo.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13a. FATHER'S NAME<br><b>Balthaser Schmitt</b>  |                                  | 13b. MOTHER'S MAIDEN NAME<br><b>Fredericka Schade</b>  |   |
| 14. NAME OF HUSBAND OR WIFE<br><b>---</b>   |                                  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |   |
| 16. SOCIAL SECURITY NO.<br><b>None</b>  |                                  | 17. INFORMANT<br><b>Lyn B. Maxwell</b> Address <b>1123a N. Union Blvd.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchial Pneumonia</b><br><b>Fracture of Right Hip.</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. }<br>DUE TO (b) _____<br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>suffered when deceased fell from bed at about May 28th, 1958, at Chronic Hospital 5600 Arsenal Street</b> |                                  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>E902:745</b>               |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  | 20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>   |   |
| 20b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.)<br><b>13 Hospital</b>  |                                  | 20c. TIME OF INJURY<br>Hour <b>5</b> a.m. <b>28</b> p.m. <b>58</b>   |   |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                                  | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.)<br><b>St Louis Mo</b>   |   |
| 20f. CITY, TOWN, OR LOCATION<br><b>St Louis Mo</b>  |                                  | 20g. COUNTY<br><b>Mo</b>   |   |
| 20h. STATE<br><b>Mo</b>   |                                  | 21. I attended the deceased from _____ to _____ and last saw her/him alive on _____<br>Death occurred at <b>517 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated. |   |
| 22a. SIGNATURE<br><b>Patrick P. Taylor Coroner</b> (Degree or title)  |                                  | 22b. ADDRESS<br><b>1300 Clark</b>  |   |
| 22c. DATE SIGNED<br><b>7-8-58</b>   |                                  | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  |   |
| 23b. DATE<br><b>7-10-1958</b>   |                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Burial Park</b>  |   |
| 23d. LOCATION (City, town, or county)<br><b>10180 Gravois</b>   |                                  | (State)<br><b>No.</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>Gegenheim Bros.</b> ADDRESS <b>6409 Gravois</b>  |                                  | 25. DATE RECD. BY LOCAL REG.<br><b>JUL 8 '58</b>   |   |
| 26. REGISTRAR'S SIGNATURE<br><b>J. Carl Smith, M.D.</b><br><b>S.P.</b>  |                                  |  |   |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Paul M. Sizemore* .....

Licensed Embalmer No. .... 4343 .....

P. O. Address.... St. Louis, Missouri

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.