THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003194
STATE FILE NUMBER

Registration District No. 313 Primary Registration District No. 1003 Registrar's No. 9

FILED JAN 26 1959

1. PLACE OF DEATH
a. COUNTY —
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis, Missouri — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Anthony — Length of stay in Ib: 3 hrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 3179 1825a So. Newstead — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First WILLIAM Middle ARTHUR Last LANGSDORF
4. DATE OF DEATH: Month January Day 2 Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: January 2, 1959
9. AGE (In years last birthday): IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours 5 Min. 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ——
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME: William J. Langsdorf
13b. MOTHER'S MAIDEN NAME: Joan Klasing
14. NAME OF HUSBAND OR WIFE: ——
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ——
(If yes, give war or dates of service): ——
16. SOCIAL SECURITY NO.: ——
17. INFORMANT: Mr. William J. Langsdorf, Address: 1825a So. Newstead

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Premature Infant - 6 mo. Gestation, Liveborn — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 776X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]
20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from On Jan. 2, 1959 and last saw her/him alive on Jan. 2, 1959.
Death occurred at 7:35 A.m. on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title): Joseph A. Mueller M.D.
22b. ADDRESS: 3177 So. Grand
22c. DATE SIGNED: 1-2-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Jan. 2, 1959
23c. NAME OF CEMETERY OR CREMATORY: Our Redeemer Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis County, Mo.
24. FUNERAL DIRECTOR ADDRESS: Beiderwieden F.H. Inc. 1936 St. Louis
25. DATE RECD. BY LOCAL REG.: JAN 2 '59
26. REGISTRAR'S SIGNATURE: J. Earl Smith MD (H.T)

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

Dr. Jos. A. Mueller
3177 So. Grand

9-12

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalme

by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Not Embalmed

Student ..... Signed .....

Signature of Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failur 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.