

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026872

SL 20377 FILED VS JUL 29 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2-6475** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY SAINT CLAIR				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N. GRAND, ST. LOUIS, MO.		Length of stay in 1b 3 days		c. CITY OR TOWN E. ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET. ADM. HOSPITAL			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 441 N. 21ST STREET		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LUCIUS Middle J. Last LANGFORD			4. DATE OF DEATH Month JULY Day 8 Year 1959					
5. SEX MALE	6. COLOR OR RACE NEGRO	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 12/16/12	9. AGE (last birthday) 46	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian			10b. KIND OF BUSINESS OR INDUSTRY HUGHES QUINN SCHMIDT, MISSISSIPPI		11. BIRTHPLACE (City and state or country) MISSISSIPPI		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME WILLIAM LANGFORD			13b. MOTHER'S MAIDEN NAME Willie Morning			14. NAME OF HUSBAND OR WIFE MILDRED LANGFORD		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-2			16. SOCIAL SECURITY NO. 329-10-3174		17. INFORMANT Address VA HOSP. RECORDS, ST. LOUIS, MO.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBARACHNOID HEMORRHAGE							INTERVAL BETWEEN ONSET AND DEATH 3 DAYS	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) HYPERTENSIVE VASCULAR DISEASE							2 YEARS	
DUE TO (c) 330 X								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) VA		20f. CITY, TOWN, OR LOCATION 7/5/59		COUNTY ST. LOUIS		STATE MO.
21. I attended the deceased from 7/5/59 to 7/8/59 and last saw him alive on 7/8/59 . Death occurred at 12:35 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) H. H. SANDSTEAD M.D.				22b. ADDRESS VAH, ST. LOUIS, MO.			22c. DATE SIGNED 7/8/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-13-59	23c. NAME OF CEMETERY OR CREMATORY NATIONAL CEMETERY		23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.			
24. FUNERAL DIRECTOR ADDRESS NASH FUNERAL HOME 111 N. 13th			25. DATE RECD. BY LOCAL REG. JUL 9 '59		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

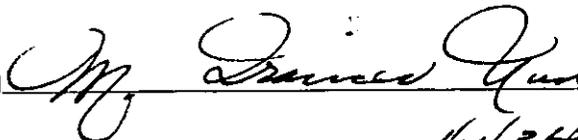
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed



Licensed Embalmer No. 4434

P. O. Address 117 N. 13th

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.