

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032128

FILED VS SEP 22 1959

Registration District No. 138 Primary Registration District No. 422D Registrar's No. 33

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Hickory</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Hickory</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Wheatland</u>		Length of stay in lb <u>6 mo</u>		c. CITY OR TOWN <u>Wheatland</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>East Wheatland</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>East Wheatland</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Elzada</u> Middle <u>Langford</u> Last <u>Langford</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>15</u> Year <u>1959</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>3-6-1879</u>		9. AGE (last birthday) <u>80</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>9</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HR Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>Hermitage, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>					
13a. FATHER'S NAME <u>George Blackwell</u>				13b. MOTHER'S MAIDEN NAME <u>Elizabeth Fink</u>				14. NAME OF HUSBAND OR WIFE <u>Emory Langford</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Heraldaino-Cross Timber, Mo</u>				Address.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arterial sclerosis</u>										Years <u></u>			
DUE TO (c) <u></u>													
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 type="checkbox"/> NO <input checked="" 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 <u></u> a.m. <u></u> p.m. <u></u>		Month, Day, Year <u></u>											
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		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 <u>1947</u> to <u>Sept. 15, 1959</u> and last saw him/her alive on <u>Sept 14, 1959</u> Death occurred at <u>2 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>J.E. Briggs, D.O.</u>				22b. ADDRESS <u>Wheatland, Mo</u>				22c. DATE SIGNED <u>9-19-59</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>Sept 17-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sumner Cemetery</u>		23d. LOCATION (City, town, or county) <u>Wheatland, Mo</u>		(State)					
24. FUNERAL DIRECTOR <u>Robert Withaway, Wheatland</u>				ADDRESS		25. DATE RECD. BY LOCAL REG. <u>4-20-1959</u>		26. REGISTRAR'S SIGNATURE <u>Mary Johnson</u>					

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 Chas. Albert Witham

Licensed Embalmer No. 4267
P. O. Address Wichita, Kan.

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.