

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

59-038426

FILED VS. NOV 16 1959 317

Registration District No. \_\_\_\_\_ Primary Registration District No. 590 Registrar's No. 2889

STATE FILE NUMBER

UNRECORDED

10/25/9/21

10/27/22 TIDCH

7/27/59 TIDCH

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF Informant

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Ann</b>		Length of stay in lb <b>5 Yr's.</b>		c. CITY OR TOWN <b>St. Ann.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>10966 St. Henry</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>10966 St. Henry</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Langton</b> Last <b>Langton</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>30</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>4/22/1912</b>	9. AGE (last birthday) <b>87</b>	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) <b>Patrolman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Metropolitan Pol.</b>		11. BIRTHPLACE (City and state or country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Unknown Langton</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Redmund</b>		14. NAME OF HUSBAND OR WIFE <b>Mary McDonough</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Agnes Kane 10966 St. Henry</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Heart disease 10 yrs</b> DUE TO (b) <b>Cerebral Vascular Accident 12 hrs</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
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 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.)		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____	
21. I attended the deceased from <b>March 1956</b> to <b>Oct 30 1959</b> and last saw him alive on <b>Oct 25 1959</b> Death occurred at <b>Oct 30 1959 6:30 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Paul D. Patterson M.D.</b> (Degree or title)				22b. ADDRESS <b>10300 St Charles Rd St Ann</b>			22c. DATE SIGNED <b>Oct 30 1959</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Nov. 2, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Louis</b>		Mo.	
24. FUNERAL DIRECTOR <b>Callan Kelly 7267 Nat'l. Bridge</b>			25. DATE RECD. BY LOCAL REG. <b>10-31-59</b>		26. REGISTRAR'S SIGNATURE <b>John B. Murphy M.D.</b>		

MS DEC 8 1959

### 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

*James A. Lamine*

Licensed Embalmer No. 4742

P. O. Address St. Louis

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.