OURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS DEC 7 1959

59-042128
STATE FILE NUMBER

MENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 211044

DOCUMENT

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Johns
Inside Limits: Yes ☒ No ☐

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 ☒ No ☐
d. STREET ADDRESS (If outside, give location): 8550a Church Rd
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First WILELMINE (Minna) Middle C. Last LANGE
4. DATE OF DEATH: Month November Day 27th, Year 1959
5. SEX: female
6. COLOR OR RACE: white
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 2/18/87
9. AGE (last birthday): 72
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): retired clerk
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Edwardsville, Ill
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Christian Lange
13b. MOTHER'S MAIDEN NAME: Caroline Fleer
14. NAME OF HUSBAND OR WIFE: none
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 494-07-9824
17. INFORMANT: Anna L. Lange, Address: 8550a Church Rd.,

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): Acute cerebral thrombosis left c.v.a. hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 40 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic H.D. disease c. hypertension — 3 yrs
DUE TO (c): old cerebral thrombosis left a mild paralysis — 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 420.0
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
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

BY AFFIDAVIT OF

21. I attended the deceased from April 1957 to 11-27-57 and last saw her alive on 11-27-57
Death occurred at 6:05 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: [signature] (Degree or title) MD
22b. ADDRESS: 832 N Broadway
22c. DATE SIGNED: 11-28-59
23a. BURIAL, CREMATION, REMOVAL (Specify): removal
23b. DATE: 12/1/59
23c. NAME OF CEMETERY OR CREMATORY: Sunset Hill Cemetery
23d. LOCATION (City, town, or county) (State): Edwardsville, Ill.
24. FUNERAL DIRECTOR: DIEDRICH FUNERAL HOME, ADDRESS: 8319 Hallsferry
25. DATE RECD. BY LOCAL REG.: 11-30-1959
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D. MB

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Elmo R. Sadure

Licensed Embalmer No. 4077

P. O. Address St Louis

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