

RID DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 8 1960

2 2254 -60-008499
STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 28 days		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hospital			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4398 Gibson			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Lang Last Lang				4. DATE OF DEATH Month 2 Day 25 Year 60				
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 2/29/82	9. AGE (last birthday) 77	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) Packer (Retired) Sieloff Packing Co.			10b. KIND OF BUSINESS OR INDUSTRY Hungary		11. BIRTHPLACE (City and state or country) Hungary			12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Stephen Lang			13b. MOTHER'S MAIDEN NAME Theresa Vatts			14. NAME OF HUSBAND OR WIFE Rose Lang		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 493-03-5602a		17. INFORMANT Address Rose Lang 4398 Gibson Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Septicemia							24 hrs.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								
DUE TO (b) Cerebro-vascular disease							24 hrs.	
DUE TO (c) Fistula-in-ano 574x							24 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic Brain Syndrome - 4 wks.					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 2:45 a.m. 2/25/60 p.m.								
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.) Chronic Hospital		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE	
21. I attended the deceased from 1/27/60 to 2/25/60 and last saw her/him alive on 2/25/60 Death occurred at 2:45 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) John W. Beckham, M.D.			22b. ADDRESS 5800 Arsenal			22c. DATE SIGNED 2/25/60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Feb. 27, 1960	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION (City, town, or county) St. Louis Co. Mo.			(State)	
24. FUNERAL DIRECTOR ADDRESS Kriegshauser 4228 S. Kingshighway Bl.			25. DATE RECD. BY LOCAL REG. FEB 26 1960		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 William B White

Licensed Embalmer No. 4281

P. O. Address 4228 10th Ave

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