URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS JUL 1 1960 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6247 60-024691 STATE FILE NUMBER

NDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Length of stay in 1b: years
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 4106 W. Penrose Street — 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): 4106 West Penrose St — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: H — Last: Lange

4. DATE OF DEATH: Month: June — Day: 16 — Year: 1960

5. SEX: male
6. COLOR OR RACE: white
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 11-4-1891
9. AGE (last birthday): 68
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 - Sign Printer
10b. KIND OF BUSINESS OR INDUSTRY: McCabe-Powers Co.
11. BIRTHPLACE (City and state or country): St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Charles Lange
13b. MOTHER'S MAIDEN NAME: Mary Naberfield
14. NAME OF HUSBAND OR WIFE: Viola Lange

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.: 490-12-4389
17. INFORMANT: Mr. Charles J. Lange — Address: 7436 Esterbrook (20

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): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerosis
DUE TO (c): 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Endocarditis - art. sclerotic

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

21. I attended the deceased from 1958, to 1960 and last saw ~~her~~ him alive on 6/4/60
Death occurred at 6:45 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: William O. Mowry M.D. — (Degree or title)
22b. ADDRESS: 362 S. Fair Ave
22c. DATE SIGNED: 6/21/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: June 20, 1960
23c. NAME OF CEMETERY OR CREMATORY: Memorial Park Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis County, Missouri

24. FUNERAL DIRECTOR: Math Hermann & Son, Inc. — ADDRESS: 2161 E. Fair Av
25. DATE RECD. BY LOCAL REG.: JUN 18 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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_____ Signed Clement McNeany

Signature of Student Embalmer

Licensed Embalmer No. 3732

P. O. Address St. Louis

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