

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 26 1960

-60-039923

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10169 STATE FILE NUMBER

| | | | | | |
|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> | | Length of stay in 1b <u>9 yrs. 9 mo.</u> | | c. CITY OR TOWN <u>St. Louis</u> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Chronic Hosp. Co. B.</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>2414 S. 4th St.</u> | |
| | | | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |

| | | | | | |
|--|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Lang</u> Last <u>Lang</u> | | | 4. DATE OF DEATH Month <u>10</u> Day <u>18</u> Year <u>60</u> | | |
|--|--|--|--|--|--|

| | | | | | | |
|--------------------|-------------------------------|---|---------------------------------|----------------------------------|--|--|
| 5. SEX <u>Male</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>4-24-79</u> | 9. AGE (last birthday) <u>81</u> | IF UNDER 1 YEAR Months <u> </u> Days <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>Ret. Lithographer</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>Germany</u> | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> |
|---|-----------------------------------|--|---|

| | | |
|--|--|--|
| 13a. FATHER'S NAME <u>Lawrence Lang</u> | 13b. MOTHER'S MAIDEN NAME <u>Salome ?</u> | 14. NAME OF HUSBAND OR WIFE <u>Kathryn Lang</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>Unk</u> | 17. INFORMANT <u>W. Wormbrodt, Ironmountain Mo.</u> |
|---|---------------------------------------|--|

| | | |
|---|--|---|
| 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>Arteriosclerotic Heart Disease</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>year</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>4200</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 | 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 <u>St. Louis, Mo.</u> |
|---|--|--|---|

| |
|---|
| 21. I attended the deceased from <u>1-16-51</u> to <u>10-18-60</u> and last saw her/him alive on <u>10-18-60</u> Death occurred at <u>8:20 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>George M. Janku, M.D.</u> | 22b. ADDRESS <u>5600 General</u> | 22c. DATE SIGNED <u>10/19/60</u> |
|--|-------------------------------------|-------------------------------------|

| | | | |
|---|------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u> | 23b. DATE <u>10-20-60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Churchyard</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u> |
|---|------------------------------|--|---|

| | | |
|---|--|--|
| 24. FUNERAL DIRECTOR <u>Southern Funeral Home</u> ADDRESS <u>6222 S. Grand Blvd., St. Louis, Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>OCT 20 1960</u> | 26. REGISTRAR'S SIGNATURE <u>Karl Smith, M.D.</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 David Van Foss

Licensed Embalmer No. 4242

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.