

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-038803
5484 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. _____

FILED NOV 9 1962	
<p>1. PLACE OF DEATH</p> <p>a. COUNTY Jackson</p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City Length of stay in lb 26 Yrs.</p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2210 East 9th St. Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE Missouri b. COUNTY Jackson</p> <p>c. CITY OR TOWN Kansas City Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) 2210 East 9th St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>
<p>3. NAME OF DECEASED First Middle Last CLARA LANG</p>	
<p>4. DATE OF DEATH Month Day Year October 25, 1962</p>	
<p>5. SEX Female</p>	<p>6. COLOR OR RACE Negro</p>
<p>7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 1/1/1900</p>
<p>9. AGE (last birthday) 62 Yrs.</p>	<p>IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.</p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p>	<p>10b. KIND OF BUSINESS OR INDUSTRY -----</p>
<p>11. BIRTHPLACE (City and state or country) Belton, Texas</p>	<p>12. CITIZEN OF WHAT COUNTRY U. S. A.</p>
<p>13a. FATHER'S NAME Jerry Riston</p>	<p>13b. MOTHER'S MAIDEN NAME Unknown</p>
<p>14. NAME OF HUSBAND OR WIFE Charlie Lang</p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no</p>	<p>16. SOCIAL SECURITY NO. -----</p>
<p>17. INFORMANT Mrs. Leon Lang</p>	<p>Address K. C. Mo.</p>
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) Myocardial Insufficiency</p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cardiac Hypertrophy</p> <p>DUE TO (c) Arteriosclerosis</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Senility</p> <p>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</p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>
<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>	
<p>20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year</p>	
<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>	<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>
<p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>	
<p>21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.</p>	
<p>22a. SIGNATURE (Degree or title) <i>M. Tillman M.D. Deputy Coroner</i></p>	<p>22b. ADDRESS <i>1618 L. din avs</i></p>
<p>22c. DATE SIGNED <i>10/27/62</i></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>	<p>23b. DATE <i>10/29/62</i></p>
<p>23c. NAME OF CEMETERY OR CREMATORY Highland Cemetery</p>	<p>23d. LOCATION (City, town, or county) (State) Kansas City, Missouri</p>
<p>24. FUNERAL DIRECTOR Mrs. Meek's Mortuary</p>	<p>ADDRESS K. C. Mo.</p>
<p>25. DATE RECD. BY LOCAL REG. <i>10-29-62</i></p>	<p>26. REGISTRAR'S SIGNATURE <i>Ruth Long</i></p>

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY: AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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 Millard B. Parker

Licensed Embalmer No. 5013

P. O. Address K.C. Mo

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.