

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

67 0005044

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 350 Primary Registration District No. 6225 Registrar's No. 11

STATE FILE NUMBER

FILED JAN 24 1967

VS 300	DATE AMENDED
Rev. 4/59	
1 <u>1080</u>	
2 <u>20425</u>	
3	
4 <u>1</u>	
5 <u>2</u>	
6	
7 <u>0</u>	
8 <u>1</u>	
9 <u>491x</u>	
10	
11	
12 <u>93-0</u>	
13 <u>1-0</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Henry</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Nevada WASHINGTON TWP.</u>		c. CITY OR TOWN <u>Clinton</u>	
Length of stay in 1b <u>5 yr. 10 mo</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital #3</u>		d. STREET ADDRESS (If outside, give location) <u>302 E. Ohio</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Della</u> Middle <u>Langdon</u> Last <u>Langdon</u>			4. DATE OF DEATH Month <u>January</u> Day <u>12</u> Year <u>1967</u>
5. SEX <u>Female</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>2-13-92</u>
9. AGE (last birthday) <u>84</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>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home making</u>	
11. BIRTHPLACE (City and state or country) <u>Lowery City, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>T. B. Park</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Bunch</u>	
14. NAME OF HUSBAND OR WIFE <u>not given</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>none</u>		17. INFORMANT Address <u>hospital records</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>Bronchopneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>For 4 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <u>Chronic brain syndrome assoc. with cerebral arteriosclerosis</u>			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 checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. 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 COUNTY STATE
21. I attended the deceased from <u>7-1-61</u> to <u>1-12-67</u> and last saw her/him alive on <u>1-12-67</u> Death occurred at <u>11:17 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>[Signature]</u>		22b. ADDRESS <u>Nevada, Mo</u>	22c. DATE SIGNED <u>1-13-67</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-14-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Englewood Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Clinton Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Sickman-Dunning FH Clinton Mo</u>		25. DATE RECD. BY LOCAL REG. <u>1-21-67</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

USE BLACK INK OR TYPEWRITER RIBBON

RECEIVED
FEB 1 1967

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 L. Douglas Ferry

Licensed Embalmer No. 4960

P. O. Address Meranda, Missouri

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.