

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

PLACE OF DEATH

County Cass
Township London
or
Village Gunn City
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 133 File No. 7774
Primary Registration District No. 4089 Registered No. 4

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Woodrow Wilson Long

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE white SINGLE MARRIED Single WIDOWED OR DIVORCED (If write the word)

DATE OF BIRTH Dec 16, 1913
(Month) (Day) (Year)

AGE 1 yrs. 3 mos. 15 ds. If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) Gunn City Mo

PARENTS
NAME OF FATHER W. G. Long
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ill.
MAIDEN NAME OF MOTHER Nancy F. Kenneth
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. G. Long
(ADDRESS) Gunn City Mo

Filed Mar 29, 1915 M. A. Hedrick
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar. 29, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar. 26, 1915, to Mar. 29, 1915,
that I last saw him alive on Mar. 26, 1915,
and that death occurred, on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
1211A9
(Duration) _____ yrs. _____ mos. 4 ds.

Contributory None
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) _____ M. D.
_____ 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL St. Mary's cem. Johnson DATE OF BURIAL Mar 31, 1915

UNDERTAKER J. H. Kauffman ADDRESS Garden City Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS who certify CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonæum*; etc., *Carcinoma*, *Sarcoma*, etc. of (name only; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY; and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

MISSOURI STATE BOARD OF HEALTH

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Cass
Township Sumner City
or
Village
or
City

Registration District No. 155 File No. _____
Primary Registration District No. 4089 Registered No. 4
(NO. _____) (Ward _____)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Woodrow Wilson Long

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M COLOR OR RACE W SINGLE S
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF DEATH _____, 1915
(Month) (Day) (Year)

DATE OF BIRTH _____, 191____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,
that I last saw h _____, 191____,

AGE _____ yrs. _____ mos. _____ ds.
IF LESS than
1 day, _____ hrs. _____ min.

and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

OCCUPATION
(a) Trade, profession, or particular kind of work _____

Bronchial Pneumonia
(Duration) _____ yrs. _____ mos. _____ ds.
None
(SECONDARY)

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country) _____

NAME OF FATHER _____

BIRTHPLACE OF FATHER
(City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER
(City or town, State or foreign country) _____

(Signed) W. A. Hedrick M. D.
Mar 29, 1915 (Address) Sumner City, Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 191____

Filed Mar 29, 1915 W. A. Hedrick
REGISTRAR

UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY INFORMATION SUPPLIED

Satisfactory Information Supplied

CERTIFICATE OF DEATH should be carefully supplied. FACTS should be stated in plain terms, so that it may be properly classified. An occupation should be stated.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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