WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

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

PLACE OF DEATH

County Ray

Township Richmond

or

Village ~~Rayville~~

or

City " (NO. ____ St.; ____ Ward)

Registration District No. 744

Primary Registration District No. 5976 B

File No. 42422

Registered No. 614

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

FULL NAME Maurice Elbert Long

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: April (Month) 28 (Day), 1911 (Year)

AGE: 6 yrs. 7 mos. 21 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): Ray Co. Mo

PARENTS

NAME OF FATHER: M. E. Long

BIRTHPLACE OF FATHER (City or town, State or foreign country): Ray Co. Mo.

MAIDEN NAME OF MOTHER: Pearl Noffginger

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ray Co. Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M E Long

(ADDRESS) Rayville Mo

Filed Dec 21, 1917. Geo W Hunt Deply REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Dec (Month) 20 (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 16, 1917, to Dec 20, 1917, that I last saw him alive on Dec 20, 1917, and that death occurred, on the date stated above, at 8 p m.

The CAUSE OF DEATH* was as follows:

Spinal Meningitis

79A 61

(Duration) ____ yrs. ____ mos. 6 ds.

Contributory (SECONDARY) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) R B Cook M. D.

Dec 21, 1917 (Address) Rayville 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 ____

PLACE OF BURIAL OR REMOVAL: Pinney Grove

DATE OF BURIAL: Dec 21 1917

UNDERTAKER: J E Brockhurst

ADDRESS: Rayville Mo

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

PLACE OF DEATH

County.....

Township..... Registration District No..... File No.....

or

Village..... Primary Registration District No..... Registered No.....

or

City ..... (NO. ..... St.: ..... Ward)

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

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... , 1.....
(Month) (Day) (Year)

AGE

.....yrs. .....mos. .....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)

PARENTS

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)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191....,
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 191....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191...., to ....., 191....,

that I last saw h..... alive on ....., 191....,

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs. .....mos. .....ds.

Contributory.....
(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	DATE OF BURIAL ....., 191....
UNDERTAKER	ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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