

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

Do not use this space.

29841

1. PLACE OF DEATH

County Clay
Township Clayton River
City Excelsior (No.)

Registration District No. 198
Primary Registration District No. 3011

File No.
Registered No. 118
St. Ward)

2. FULL NAME Adam L. Long

(a) Residence. No. Saratoga Ave St. 0 Ward. Clarence Mo
(Usual place of abode)
Length of residence in city or town where death occurred 5 yrs off and on and on mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF Jennie G. Long

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 11 1847

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
80 8 ✓

8. OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Ohio
Simon Long

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Va.

12. MAIDEN NAME OF MOTHER Un known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Un known

14. INFORMANT Simon Long
(Address) Clarence Mo

15. FILED 10/15 19 27 W.D. Brown
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3 16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/14 1927
17. HEREBY CERTIFY That I attended deceased from 9-25, 1927, to 10/14, 1927, that I last saw him alive on 10/14, 1927, and that death occurred, on the date stated above, at Clarence Mo.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

107A
120B
102 Bronchial Pneumonia
(duration) yrs. mos. 3 ds.

CONTRIBUTORY (SECONDARY) General Debility and
Exhaustion of Respiration (duration) yrs. mos. 20 ds.

18. WHERE WAS DISEASE CONTRACTED?
Place death.

DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? General Ex

(Signed) H. J. Clark M. D.

, 19 (Address) Excelsior Spgs Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Clarence Mo. DATE OF BURIAL Oct 16 1927

20. UNDERTAKER John C. Prasher ADDRESS Excelsior

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

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Clay

Registration District No. 198

File No.

Township

Primary Registration District No. 3011

Registered No. 118

City Ex. Spring (No.) St. Ward)

2. FULL NAME

Adam D. Long

(a) Residence No. St. Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

W

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Great day not known

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 2 1847

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

FILED 12/7 1927 Y. D. Carson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 14 1937

17. I HEREBY CERTIFY That I attended deceased from

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

..... (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D. , 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

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

SUPPLEMENTARY

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