

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

Do not use this space.

35112

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 1003
City St. Louis (No. 5644) Bartmer St. _____ Ward _____
Registered No. 10262

2. FULL NAME

(a) Residence No. _____ St. 15 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown 1885

7. AGE YEARS MONTHS DAYS If LESS than 1 day, tra. or min.
abt. 42 - - - - -

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Joseph J Long

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

12. MAIDEN NAME OF MOTHER Thekla Surmayer

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

14. INFORMANT Thekla Long
(Address) 5644 Bartmer

15. NOV 16 1927 max b Starkey REGISTERAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-15-1927

17. I HEREBY CERTIFY, That I attended deceased from ingl
1927, to 11/15/27, 1927
that I last saw h. alive on 11/12/27 1927, and that death occurred, on the date stated above, at 4 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Valvular Dis
or Endocarditis
IIA

(duration) _____ yrs. _____ mos. _____ da.
CONTRIBUTORY General Edema
(SECONDARY) (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED NO
IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? All tests
(Signed) Dean Hugh Carlson, M. D.

11/16, 1927 (Address) Beaubien Bldg.

*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 Calvary DATE OF BURIAL 11-17 1927

20. UNDERTAKER Arthur J. Womcley ADDRESS 2039 Wash St

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.

Red Hill Pass

Humboldt Bay

July 0251