

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

Do not use this space.

3098

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City St. Louis 220 (No. 5600 Arseual)

File No.

Registered No. 1712

2. FULL NAME

Ben Austin Long BEN AUSTIN LONG

(a) Residence No. 530 Montrose St. 18 Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 9 mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

Male Colored Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March-11-1925

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>2</u>	<u>10</u>	<u>6</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
 (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) Mo

10. NAME OF FATHER Ben Long

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

12. MAIDEN NAME OF MOTHER Anna Staubeck

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

14. INFORMANT Anna Long (Mother)
 (Address) 530 Montrose

15. FILED 11 1928 max e starkoff
 19..... REGISTER

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan-17 1928

I HEREBY CERTIFY That I attended deceased from Jan-16 1928 to Jan-17 1928 that I last saw him alive on Jan-17 1928 and that death occurred, on the date stated above, at 8:20 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bacteria, Laryngeal, Pharyngeal and Nasal 10

10 107B (duration) 0 yrs. 0 mos. 5 da.

CONTRIBUTORY Pneumonia (SECONDARY) Secondary (duration) 0 yrs. 0 mos. 2 da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: 530 Montrose

19. DID AN OPERATION PRECEDE DEATH? NO DATE OF.....

20. WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Laboratory
 (Signed) George H. Garrison, M.D.
 , 19 (Address) Isolation Hospital

*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.

21. PLACE OF BURIAL, CREMATION, OR REMOVAL Washington Park DATE OF BURIAL 1-20-1928

22. UNDERTAKER W. S. Widmeyer ADDRESS 4202

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.

