

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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... **St. Louis** Primary Registration District No. **1003**
 City..... **St. Louis** (No. **Childrens Hospital**)

File No. **14986**
 Registered No. **13899**
 St. _____ Ward _____

2. FULL NAME

Joseph Long
 (a) Residence, No. **400 East Davis**, St. **7** Ward. _____
 (Usual place of abode)

Length of residence in city or town where death occurred **Life** yrs. _____ 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 **W.** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Infant**
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **3-11-28**

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	—	—	28	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Infant**
 (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 **John Long**

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

12. MAIDEN NAME OF MOTHER **Alice Schoutz**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **St. Louis**
 (STATE OR COUNTRY) **Mo.**

14. INFORMANT **Am. Snygel**
 (Address) **St. Louis Children's Hospital**

15. FILED **APR - 9 1928**
Maple St. Kinder REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **4-8-1928**

17. I HEREBY CERTIFY, That I attended deceased from **4/6/1928**, to **4/8/1928**, and that I last saw him alive on **4/8/28**, 19 **28**, and that death occurred, on the date stated above, at **2:50** p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Prematurity
 (duration) _____ yrs. _____ mos. **28** ds.

CONTRIBUTORY **Branchopneumonia, primary**
 (SECONDARY) _____ (duration) _____ yrs. _____ mos. **3** ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, **home**

DID AN OPERATION PRECEDE DEATH? **no** DATE OF _____

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **Phys. Exam, Histology**
 (Signed) **Russell C. Boyd** M. D.

April 8, 1928 (Address) **St. L. Childrens Hsp.**

*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 **Mt. Olivet Cemetery** DATE OF BURIAL **4/10/1928**

20. UNDERTAKER **Southern W. Co** ADDRESS **7315 S. Broadway**

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.

