

**MISSOURI STATEBOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.
26257

1. PLACE OF DEATH

County..... Registration District No. **701**
Township..... Primary Registration District No. **1005**
City **St. Louis Mo.** (No. **St. Johns Hospital**)..... St. Ward)

File No.....
Registered No. **7467**
St. Ward)

2. FULL NAME William LeRoy Long

(a) Residence. No. **3936 Walsh St.** 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. 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) **Married**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Nov. 9, 1980.**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	48	8	8	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Street car conductor**
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer **Public Service Co.**

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) **Indiana**

10. NAME OF FATHER **Levi Long**

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

12. MAIDEN NAME OF MOTHER **Elizabeth Tyler**

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

14. INFORMANT Grace Long
(Address) 3936 Walsh St.

15. FILED 19 May 1981 REGISTRAR May C. Stark

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **July 17 - 19 29**

17. I HEREBY CERTIFY, That I attended deceased from July 16, 1929, to July 17, 1929, that I last saw him alive on July 17, 1929, and that death occurred, on the date stated above, at 11:25 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Intestinal Obstruction (acute) due to an ulcer

12 1/2 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Verruca due to skin obstruction (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF LOCAL PLACE OF BIRTH

DID AN OPERATION PRECEDE DEATH? yes DATE OF July 16-29
WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) C. Byland M. D.

1/18 19 29 (Address) 3901 Park Ave

*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 **Lake wood Park Cemetery** DATE OF BURIAL **7-20-19 29**

20. UNDERTAKER McLaughlin ADDRESS 1631 Missouri

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.

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Dr. Byland's certificate on page 2

