

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

Do not use this space.

**1. PLACE OF DEATH**

County Jackson Registration District No. 1002  
 Township Haw Primary Registration District No. 399  
 City Kansas City (No. 2300) Laurel

File No. 1125  
 Registered No. 1111  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Robert Joe Long  
 (a) Residence, No. St. Anthony's Home St. 11 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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 8-23-29

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
4 11

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Mine  
 (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) Unknown

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Mae Long

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

14. INFORMANT Sister Mary Joseph  
 (Address) 23 St. + College Ave

15. Jan 9, 1930 m. n. Croove  
 FILED \_\_\_\_\_ REGISTRAR Asst

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 4 1930

17. I HEREBY CERTIFY That I attended deceased from Dec 29, 1929 to Jan 4, 1930  
 that I last saw h. alive on Jan 2, 1930 and that death occurred, on the date stated above, at 2:40 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Lobar pneumonia  
108

CONTRIBUTORY (SECONDARY) None  
 (duration) yrs. mos. ds.

18. WHEN WAS DISEASE CONTRACTED None  
 IF NOT AT PLACE OF DEATH. \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? None

(Signed) A. H. Dwyer  
1/5, 1930 (Address) 214 Medical Auto 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 DATE OF BURIAL

St. Marys Cemetery Jan 9 - 1930

20. UNDERTAKER ADDRESS

John W. Wagner 1409 Grand

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.

31

