

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

Do not use this space.

9258

PLACE OF DEATH

County Johns on
Township Rose Hill
City..... (No..... St..... Ward)

Registration District No. 437
Primary Registration District No. 5594

File No.....
Registered No.....

2. FULL NAME Henry Long

(a) Residence. No..... St..... 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 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 Husband of Alba Long		
6. DATE OF BIRTH (MONTH, DAY AND YEAR)		
7. AGE 49	YEARS 4	MONTHS 11
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Farmer (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)

PARENTS	10. NAME OF FATHER Jacob Long
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>unknown</u> (STATE OR COUNTRY)
	12. MAIDEN NAME OF MOTHER <u>Marie Worden</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>unknown</u> (STATE OR COUNTRY)

14. INFORMANT (Address).....

15. FILED 4441197 J. F. Sheffer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **March 26** 19 **30**

17. I HEREBY CERTIFY, That I attended deceased from **November 1929** to **March 26**, 19 **30**
that I last saw him alive on **March 26**, 19 **30**, and that death occurred, on the date stated above, at **9** P.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Myocarditis

CONTRIBUTORY (SECONDARY)
90 B

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

DID AN OPERATION PRECEDE DEATH? **No** DATE OF.....
WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) J. F. Sheffer, M. D.
, 19 (Address) La Porte Mo

*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 Hornsby Cem DATE OF BURIAL Mar 28 19 30

20. UNDERTAKER T. W. Goodman ADDRESS Halls, Mo

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.

JUN 23 1942

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Johnson Registration District No. 437 File No.
 Township West Hill Primary Registration District No. 5594 Registered No.
 City (No., St. Ward)

2. FULL NAME Henry Long

(a) Residence. No. St. 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 15 1890

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
49 4 11

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Mo
 (STATE OR COUNTRY)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT Mrs. H Long
 (Address) Golden mo

15. FILED Apr 10 1930 J. S. Shaffer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/26 1930

17. I HEREBY CERTIFY, That I attended deceased from
 to 19.....
 that I last saw h. day of 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?
 DID AN OPERATION PRECEDE DEATH? DATE OF
 WAS THERE AN AUTOPSY?
 WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) M. D.
 , 19 (Address)

*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

20. UNDERTAKER ADDRESS

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

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