

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

Do not use this space.

12670

**1. PLACE OF DEATH**

County Jackson Registration District No. 399

Township Kaw Primary Registration District No. 1002

City Kansas City

K. C. General Hospital

File No. \_\_\_\_\_

Registered No. 1597

St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Sam Long

(a) Residence. No. 1004 Lydia Ave. St. 2 Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 2 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) July 4, 1877

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>53</u>	<u>9</u>	<u>6</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work R. R. Employee

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer UNemployed

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

10. NAME OF FATHER Frank Long

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

12. MAIDEN NAME OF MOTHER Marietta (?) Link

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

14. INFORMANT Mrs. Grace Long  
(Address) 1004 Lydia Ave.

15. FILED 4/11 19 30 M. M. Crowe REGISTRAR  
ant

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 10, 1930

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

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

Alcoholism  
75 B

CONTRIBUTORY (SECONDARY) 66 B  
(duration) \_\_\_\_\_ yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS Autopsy  
(Signed) Shaver M. Hays M. D.

4/10 19 30 (Address) Daddy Crowe

\*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 Worthington, Minn. DATE OF BURIAL Apr. 11, 1930

20. UNDERTAKER J. P. Louis Funeral Director, K. C., Mo. 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

