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

41891

1. PLACE OF DEATH
County: Wright
Township: Montgomery
City: (No. St. Ward)
Registration District No.: 911
Primary Registration District No.: 6227
File No.:
Registered No.:

2. FULL NAME: Jackson Long
(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(Usual place of abode)
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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 3-6-1833

7. AGE

| YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or ...min. |
|---|---|---|---|
| 97 | 9 | 21 | |

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (CITY OR TOWN): Tenn
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER: unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN):
(STATE OR COUNTRY): unknown
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN):
(STATE OR COUNTRY): unknown

14. INFORMANT: Jane Long
(Address): Manes Mo

15. FILED 12-30 1930 B.L. Johnston REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR): 12-27 1930

17. I HEREBY CERTIFY, That I attended deceased from 0, 19 0, to 0, 19, that I last saw h. alive on, 19, and that death occurred, on the date stated above, at 5 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Old age

(duration) yrs. mos. ds.

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) B.L. Johnston, M.D.
, 19 (Address) Manes 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: Manes Cemetery
DATE OF BURIAL: 12-28 1927

20. UNDERTAKER: W. V. Wade
ADDRESS: Manes Mo

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.

V. S. Dec. 28

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## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

**1. PLACE OF DEATH**

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., .....St. .....

**2. FULL NAME** .....

(a) Residence. No..... St., .....Ward. .....
(Usual place of abode) (If nonresident give city or town

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

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

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

7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, .....hrs. or .....min.

8. OCCUPATION OF DECEASED

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

(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

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 .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

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

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(duration).....yrs. .....

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....

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).....

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLE (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTA HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE

20. UNDERTAKER | ADDR