

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

Do not use this space.

30650

1. PLACE OF DEATH

County Reynolds
Towship
City Ellington, Mo.

Registration District No. 748
Primary Registration District No. 140007

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Rorice Clyde 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

2 MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

M W Married

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

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

7. AGE

YEARS

MONTHS

DAY

IF LESS than 1 day, hrs. or min.

43

X

X

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

Farming

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

10. NAME OF FATHER

Long

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Don't know

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Don't know

14.

INFORMANT

(Address)

Elmer Long
Ellington, Mo.

15.

FILED

19

REGISTRAR

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

Sept. 3 1933

17.

I HEREBY CERTIFY, That I attended deceased from Aug 8, 1933, to Sept 3, 1933 that I last saw him alive on Sept 12, 1933, and that death occurred, on the date stated above, at 1 A m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Tumor of brain
550

CONTRIBUTORY (SECONDARY)

Arterial atherosclerosis
(duration) 1 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

8 DID AN OPERATION PRECEDE DEATH. DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST, CONFIRMED DIAGNOSIS

(Signed) A. F. Bugg, M. D.

9/3, 1933 (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

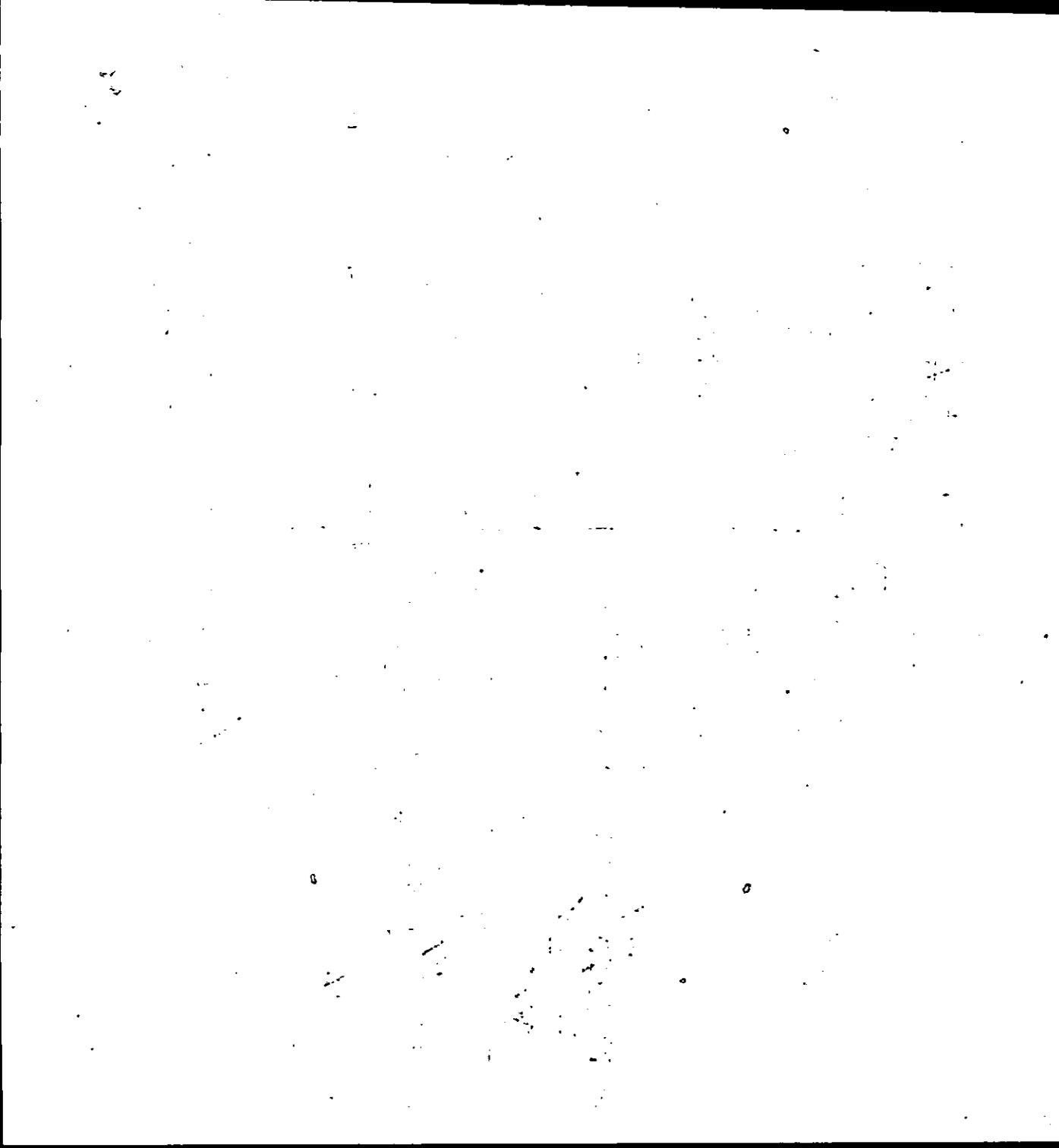
DATE OF BURIAL

20. UNDERTAKER

ADDRESS

19

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state how amount of patient EXACTLY.



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Greene
Township Wright
City Wright (No.)

Registration District No. 748
Primary Registration District No. 4449

File No.
Registered No.
St. Ward)

2. FULL NAME

(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 <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>M</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Addie Long</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Nov. 13 - 1889</u>		
7. AGE YEARS <u>43</u>	MONTHS <u>9</u>	DAYS <u>20</u>
		IF LESS than 1 day, hrs. or min.

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Prinning</u>
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
	10. Date deceased last worked at this occupation (month and year)
	11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
Mo Lang

13. NAME
Lang

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME
Jane Jones

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)
Wright

18. BURIAL, CREMATION, OR REMOVAL
PLACE Wright Cemetery DATE 11/13/33

19. UNDERTAKER (ADDRESS)
Wright

20. FILED 11/15/33 Essie Evans Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 3, 1933

22. I HEREBY CERTIFY, That I attended deceased from Aug 8 to Sept 3, 1933
I last saw alive on Sept 12, 1933 Death is said to have occurred on the date stated above, at 11 m.
The principal cause of death and related causes of importance were as follows:

General of heart
55
General Asthma
Date of onset

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....
Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify
(Signed) A. J. Bugg, M. D.

(Address) Ellington, Mo.

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

MISSOURI STATE BOARD OF HEALTH
SUPPLEMENTARY

S-30650