

NOV 18 1935

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

Do not use this space.

1. PLACE OF DEATH

County Buchanan

Registration District No. 85

Township

Primary Registration District No. 1001

City St Joseph (No. State Hosp # 2)

File No. 31926

Registered No. 1073

St. _____ Ward _____

2. FULL NAME Wm F Long

(a) Residence, No. St Joseph Mo St. _____ Ward _____

(If nonresident, give city or town and State) St Joseph Mo

Length of residence in city or town where death occurred — yrs. — mos. 9 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) Jan. 15-1871

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 64 9 2

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Brick Mason

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) _____

13. NAME _____

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

15. MAIDEN NAME _____

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

17. INFORMANT (ADDRESS) State Hosp Records St Joseph Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE St Joseph Mo DATE 10-18 1935

19. UNDERTAKER (ADDRESS) Schooler Bros St Joseph Mo

20. FILED 10-19 1935 John R Bender Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 17 1935

22. I HEREBY CERTIFY, That I attended deceased from Oct 8 1935 to Oct 17 1935

I last saw him alive on Oct 16 1935 Death is said

to have occurred on the date stated above, at 6:30 a.m.

The principal cause of death and related causes of importance were as follows:

Chronic Interstitial Nephritis Date of onset ?

Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? No

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? No

If so, specify _____

(Signed) J. R. Bender M. D.

(Address) State Hosp # 2

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 CAREFULLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

