

REC'D FEB 21 1939

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

1441

Do not use this space.

1. PLACE OF DEATH

(a) County Adair Registration District No. 4
(b) Township 1 Primary Registration District No. 3001 Registered No. 12
(c) City Kirksville (d) Street No. Green Smith Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. 12 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

520 Jerry Long
(a) Residence, No. Green City, Mo. St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S.

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 30-1936

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
2 6 16

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

9. Industry or business in which work was done, as 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) W. Sullivan Co. Mo.

FATHER 13. NAME Hester Long

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Near Green City, Sullivan, Co. Mo.

MOTHER 15. MAIDEN NAME Maurine Pipes

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Near Cora, Sullivan, Co. Mo.

17. INFORMANT (ADDRESS) Maurine Long, Green City, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Quasco Co. DATE 1-17-1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Alex N. Bent, Green City, Mo.

20. FILED Jan 19, 1939 Spencer L. Freeman Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-15-1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1939, to Jan 15th, 1939

I last saw him alive on Jan. 15th, 1939 Death is said

to have occurred on the date stated above, at 11:50 p. m.

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

Pneumococcic peritonitis

Date of onset

1-2-39

Other contributory causes of importance: 108

Lobar pneumonia

Name of operation Laparotomy for drainage Date of 1-2-39

What test confirmed diagnosis? YES Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? XXX Date of injury....., 19.....

Where did injury occur? XXX (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..... X XXXX

24. Was disease or injury in any way related to occupation of deceased? NO

If so, specify XXXXX

(Signed) E. S. Smith, M. D.

(Address) Grim-Smith Hosp. Kirksville, 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.

RECEIVED

District Health Officer No. 10

District File Number 10-39-18

Date Filed FEB 9 1930

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, _____, or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1441
Registrar's No. 12-

Registration District No. Primary Registration District No.

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Keokuk
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME Jerry Long
(b) If veteran, name was
(c) Social Security No.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced
(b) Name of husband or wife 6. (c) Age of husband, or wife, if alive

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 2 Months 6 Days 16 If less than one day

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant (b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director (b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A. years

20. DATE OF DEATH: Month Jan. 15 day 1939 year hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19 that I last saw him alive on and that death occurred on the date and hour stated above.

Immediate cause of death pneumonia, coccic peritonitis
Due to Lobar pneumonia

Other conditions (Include pregnancy within 3 months of death)

Major findings: Laparotomy for drainage 1-21-39 - of autopsy (of peritonitis)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature E. B. Smith (M. D. or other) Address Date signed

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

