

JUN 19 1939

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

19139
Do not use this space.

1. PLACE OF DEATH
 (a) County Macon Registration District No. 5264312
 (b) Township Lynn Primary Registration District No. 574701 Registered No. _____
 (c) City Atlanta, Mo. (d) Street No. _____ 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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
 2. PRINT FULL NAME Joseph Long
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

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 Cha Long
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 7-1858
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 84 5 11
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired farmer
 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 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May-18-1939
 22. I HEREBY CERTIFY, That I attended deceased from May 1, 1939, to May 18, 1939
 I last saw him alive on May 13, 1939, 1939. Death is said to have occurred on the date stated above, at 1:30 p.m.
 The principal cause of death and related causes of importance were as follows:
Blue- and cardiac weakness Date of onset _____
weakness
 Other contributory causes of importance: Senility

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Brandstowe, Ill.

FATHER 13. NAME George Long

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

MOTHER 15. MAIDEN NAME Mary Barr

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

17. INFORMANT (ADDRESS) Cha Long
Atlanta Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Labor DATE May 19-1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) H. M. Bonding
Atlanta Mo.

20. FILED June 1, 1939 John McNeely Local Registrar

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) G. Dodge, M. D.
 (Address) Atlanta 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 10-39-1066

Date Filed JUN 7 1939

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, ^{nat} _____

or by _____

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

Signed _____

Licensed Embalmer No. 1750

P. O. Address Atlanta Mo.

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

19139

Do not use this space.

1. PLACE OF DEATH

(a) County Macon

Registration District No. 526

(b) Township

Primary Registration District No. 4312

(c) City Atlanta

(d) Street No.

Registered No.

(e) Length of residence in city or town where death occurred

(If death occurred in Hospital or Institution, write its name instead of street and number)
yr. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Joseph Long St.

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

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

m

w

m

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 12-7-1858

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, hrs.
or min.

80

5

11

OCCUPATION

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)

FATHER

13. NAME

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

MOTHER

15. MAIDEN NAME

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

17. INFORMANT
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE

DATE

19

19. FUNERAL DIRECTOR
(ADDRESS)

20. FILED

July 7 1939

Ruth McNeely
Local Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-18, 1939

22. I HEREBY CERTIFY, That I attended deceased from

19..... to....., 19.....

I last saw h..... alive on....., 19..... Death is said

to have occurred on the date stated above, at..... m.

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

Date of onset

Other contributory causes of importance:

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) H. C. Lyda, M. D.

(Address) Atlanta, Ga

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

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

