

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 44372

AN 12 1940

Registration District No. 716

Primary Registration District No. 5945

Registrar's No. 14

1. PLACE OF DEATH:

(a) County Pulaski
 (b) City or town Rural -- Tavern Township
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 46
(Specify whether
 In this community 40 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pulaski
 (c) City or town Rural
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 22nd
 year 1939 hour 5 minute 45 A. M.

21. I hereby certify that I attended the deceased from Dec. 21st, 1939 to Dec 22nd, 1939; that I last saw him alive on Dec 21st, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Diabetes Mellitus
 Due to ✓
 Due to ✓

Duration
12/21/39
12/22/39
24 hrs

Other conditions ✓
(Include pregnancy within 3 months of death) 59
 Major findings:
 Of operations ✓
 Of autopsy ✓

PHYSICIAN
 Underline the cause to which death should be charged statistically

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)
 (a) Means of injury ✓
 23. Signature W. J. Bell (M. D. or other) ✓
 Address Crocker Mo Date signed 12/22/39

3. (a) PRINT FULL NAME John Burks Long 520

8. (b) If veteran, name war ✓ 8. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Rhumina Long 6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased Nov. 24 1866
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>11</u>	<u>28</u>	hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business 1

12. Name William Long 1

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

14. Maiden name Jane Long

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

16. (a) Informant's own signature Mrs. Rhumina Long

(b) Address Crocker, Missouri

17. (a) _____ (b) Date thereof Dec. 24 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pleasant Hill Cem.

18. (a) Signature of funeral director J. L. HOOPS & SONS

(b) Address Crocker, Missouri

19. (a) 12/22/39 (b) _____
(Date received local registrar) (Registrar's signature)

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.

RECEIVED

District Health Officer No. 5,

Signed.....

District File Number 140 21

Licensed Embalmer No.....

Date Filed 11040

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.