

No. 2
10-39
17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

3965

State File No.

Registrar's No.

Registration District No. 810

Primary Registration District No. 4488

6055

6

1. PLACE OF DEATH:

(a) County Scottland
(b) City or town S. W. Moore
(c) Name of hospital or institution: Country Home
(If not in hospital or institution, write street number or location) 3
(d) Length of stay: In hospital or institution 15 years
(Specify whether) 3
In this community 40 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County W
(c) City or town Waverly
(If outside city or town limits, write "RURAL")
(d) Street No. Waverly
(If rural, give location)
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME

S U P I A L O N G

3. (b) If veteran, name war

8. (c) Social Security No.

4. Sex Female 5. Color or race white
6. (b) Name of husband or wife Henry Long
6. (c) Age of husband or wife if alive 2 years
7. Birth date of deceased Aug 2 1877
(Month) (Day) (Year)

8. AGE: Years 62 Months 6 Days 9
If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business
12. Name Isaac Todd
18. Birthplace Madison Co Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Eizabeth Anderson
15. Birthplace Madison Co Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. G. Hales
(b) Address Mt Sterling Ill

17. (a) Burial (b) Date thereof Jan 27 '40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Heard at Mt Sterling

18. (a) Signature of funeral director Geetha Baskitt
(b) Address Memphis Mo

19. (a) F. E. Parish (Registrar's signature)
(Received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 24
year 1940 hour 4:00 minute 20 P.M.

21. I hereby certify that I attended the deceased from Jan 24 1940 to Jan 24 1940
that I last saw him alive on Jan 24 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer Rectum
X Bowel

Due to
Due to
Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration
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)
23. Signature W. E. Alexander (M. D. or other)
Address Memphis Mo Date signed Jan 26

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

99

46

RECEIVED

District Health Officer No. 10

District File Number 2-40-444

Date Filed FEB 14 1940

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, _____

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed Albert C Gerth

Licensed Embalmer No. 3689

P. O. Address Memphis 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3965-7

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 810

Primary Registration District No. 6053-

Registrar's No.

1. PLACE OF DEATH:

(a) County. Scotland
(b) City or town. _____
(If outside city or town limits, write "RURAL" and name of township)
(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. _____
(Specify whether
In this community. _____
years, months or days)

3. (a) PRINT FULL NAME

India Long

3. (b) If veteran, name war. _____ 3. (c) Social Security No. _____

4. Sex. 7 5. Color or race. W
6. (a) Single, widowed, married, divorced. DW
6. (b) Name of husband or wife. _____ 6. (c) Age of husband, or wife, if alive. _____ years
7. Birth date of deceased. _____ (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day min.
62 6 9 _____

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) _____ (b) Date thereof. _____ (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation. _____

18. (a) Signature of funeral director. _____

(b) Address. _____

19. (a) _____ (b) _____ (Date received local registrar) (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 24
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death. Cancer of rectum
& Bowels & cause of
restless by Cancer thing
Due to. about 3 yrs from the
anus

Due to. Don't know

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations. 4/6

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) (e) Means of injury. _____

23. Signature. W. E. Alexander (M. D. or other)

Address. Memphis Mo Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

