

FD APR 12 1940
Registration District No. _____

Primary Registration District No. 1001

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

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri Methodist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution eight days
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Archibald Carter Long

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

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

6. (b) Name of husband or wife Esta 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased 8 (Month) 26 (Day) 1869 (Year)

8. AGE: Years 70 Months 7 Days 2 If less than one day _____ hr. _____ min.

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

10. Usual occupation Medical Doctor

11. Industry or business

MOTHER FATHER { 12. Name Harvey A. Long
13. Birthplace Indiana (City, town, or county) (State or foreign country)
14. Maiden name Susana Ross
15. Birthplace Harrison County Missouri (City, town, or county) (State or foreign country)

16. (a) Informant Esta Long

(b) Address St. Joseph Missouri

17. (a) Removal (b) Date thereof 3-31-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Carter Cemetery

18. (a) Signature of funeral director J. E. ...

(b) Address St. Joseph Missouri

19. (a) 3/28/40 (b) H. J. Nestlebaum
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Worth
(c) City or town Sheldon
(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 March day 28
year 1940 hour 10 minute 35 P. M.

21. I hereby certify that I attended the deceased from February 26 1940, to March 28 1940 that I last saw him alive on March 28 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary edema Duration 1 1/2 hrs

Due to Arterio sclerotic heart disease 6 mos

Due to _____
Other conditions (Include pregnancy within 3 months of death) 45A⁷

PHYSICIAN
Major findings:
Of operations:
Of autopsy:
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? _____

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

23. Signature J. J. Nowden (M. D. or other) _____
Address Kirkpatrick Bldg Date signed April 29

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.