

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.

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

Do not use this space.

See also 8591-40  
11158  
Registered No. 11158  
St. \_\_\_\_\_ Ward \_\_\_\_\_

1. PLACE OF DEATH

County Howell Co Registration District No. 3  
Township Spring Creek Primary Registration District No. 55  
City Pottersville Mo (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

William Taylor Long  
(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. 40 mos. \_\_\_\_\_ ds. \_\_\_\_\_  
How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

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 Mary Jane Long

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
8 1/2 8 1/2 6 7

OCCUPATION  
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as silk mill, 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) Georgia state

MOTHER FATHER  
13. NAME Esie Long

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

15. MAIDEN NAME Dinia Wells

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

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE Pottersville Mo DATE April 26 1940

19. UNDERTAKER (ADDRESS) Missouri Burial Association  
Glennsville Mo

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_ Registrar \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 18 1940  
22. I HEREBY CERTIFY, That I attended deceased from April 15, 1940, to April 15, 1940  
I last saw him alive on April 15, 1940. Death is said to have occurred on the date stated above, at 2:45 a.m.

The principal cause of death and related causes of importance were as follows:  
Lobar Pneumonia Date of onset \_\_\_\_\_

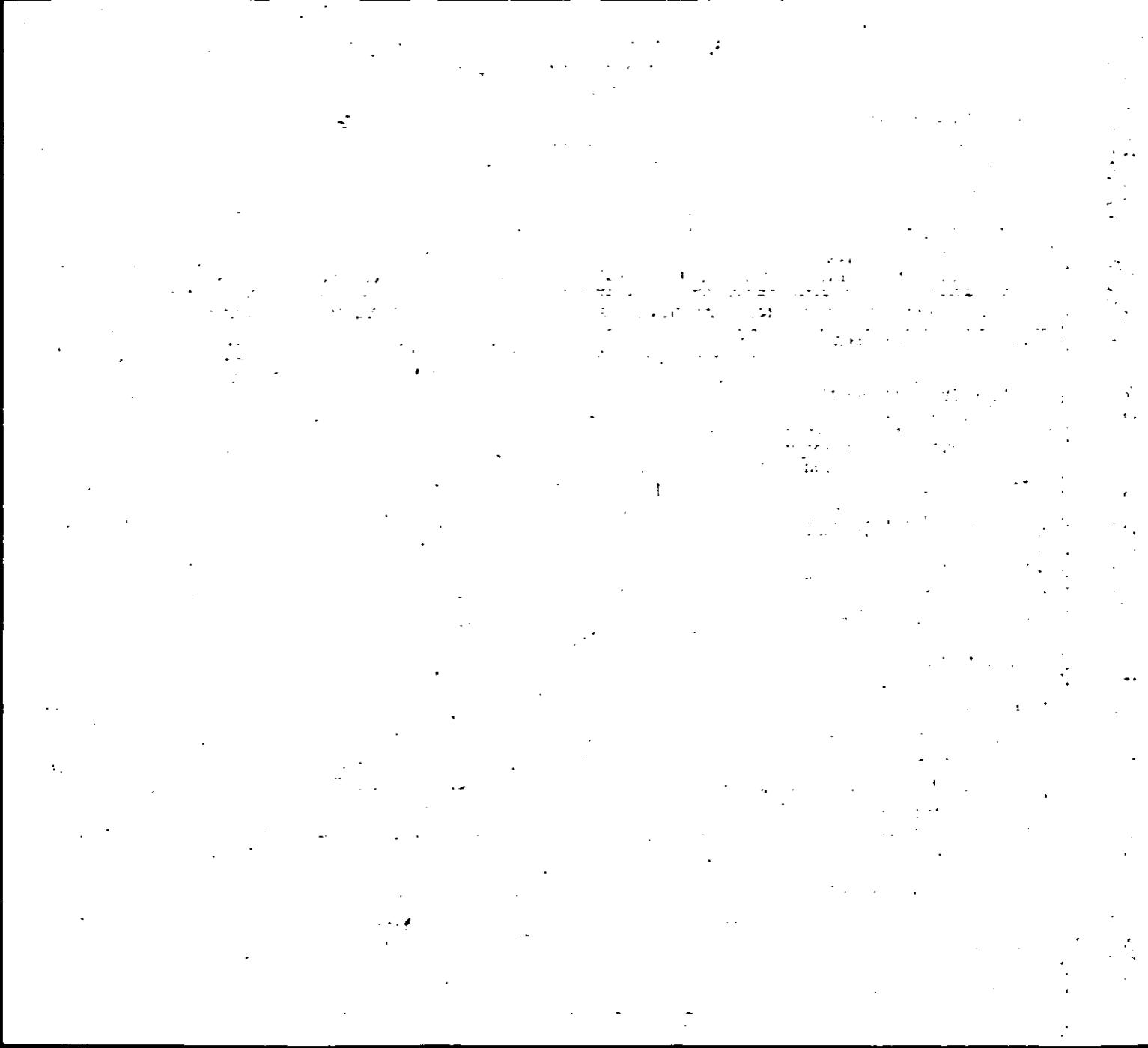
Other contributory causes of importance:  
Senility

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? No  
If so, specify \_\_\_\_\_  
(Signed) R.A. Sparks, M. D.  
341 (Address) West Plains, Mo.



MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 11158

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 384

Primary Registration District No. 5539

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County Howell  
(b) City or town Spring Creek  
(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 \_\_\_\_\_  
In this community 75 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Wm Taylor Long

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

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

6. (b) Name of husband or wife Mary Jane Carrico Long 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased October 11, 1855  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>84</u>	<u>6</u>	<u>7</u>	hr. min.

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Isaac Long 13. Birthplace Georgia  
(City, town, or county) (State or foreign country)

14. Maiden name Diana Wells 15. Birthplace Georgia  
(City, town, or county) (State or foreign country)

16. (a) Informant Wash Long

(b) Address Pottersville, Mo.

17. (a) Burial (b) Date thereof 4-20-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pottersville, Mo.

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Ms 943-40 (b) Vida K SIMONS  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell  
(c) City or town Pottersville  
(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 Apr day 18  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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. R. G. Sparks (M. D. or other) \_\_\_\_\_  
Address West Plains Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

1940  
S-11158