

No. 2
11-10-39
5-17-39
I X21492

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **16830**
Registrar's No. **4308**

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Luke's Hospital
(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) 505

3. (a) PRINT FULL NAME William Irving Longmire

8. (b) If veteran, name war No. 3. (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 Ruby 6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased Oct. 2 1887
(Month) (Day) (Year)

8. AGE: Years 52 Months 7 Days 10 If less than one day hr. min.

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

10. Usual occupation District Manager

11. Industry or business Mutual Benefit Ins. Co.

12. Name William W. Longmire

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

14. Maiden name Adeline Lindsey

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

16. (a) Informant Mrs. W. I. Longmire

(b) Address Columbia, Mo.

17. (a) Removal (b) Date thereof 5-14-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Monroe City, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) MAY 14 1940 (b) J. B. [Signature]
(Date received local registrar) (Signature of registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town Columbia (If outside city or town limit, write "RURAL") NR
(d) Street No. 1213 East Broadway
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 12
year 1940 hour 11 minute 37 P. M.

21. I hereby certify that I attended the deceased from May 9
1940 to May 12 1940

that I last saw him alive on May 12 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Spongiblastoma of rt. frontal lobe of brain

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 53

Major findings: Brain tumor

Of autopsy Brain tumor

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? Yes (Specify type of place) (e) Means of injury 1

23. Signature George J. [Signature] (M. D. or other)
Address St. Luke's Hosp. Date signed 5-13-40

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

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

Albert G. Hoffe

Licensed Embalmer No. 2971

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.