

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.

Registration District No. 384 Primary Registration District No. 5

1. PLACE OF DEATH:
(a) County Howell
(b) City or town Pottersville
(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 _____
(Specify whether _____)
In this community 40 years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Howell
(c) City or town Pottersville
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME William Taylor Long 520
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 18th
year 1940 hour 2 minute 45 A.M.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mary Jane Long 6. (c) Age of husband or wife if alive 69 years
7. Birth date of deceased October 11, 1855
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from April 15, 1940, to April 15, 1940.
that I last saw him alive on April 15, 1940, and that death occurred on the date and hour stated above.
Immediate cause of death Heart failure Duration _____

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

Due to Labor Pneumonia
Due to _____
Other conditions (Include pregnancy within 3 months of death) 108
Major findings: Of operations _____
Of autopsy _____

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

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Therlo Long
(b) Address Pottersville, Missouri
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 O. B. McClure
(b) Address Gainesville, Missouri
19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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? 3/11
(Specify type of place) While at work? (e) Means of injury _____
23. Signature P. A. Sparks (M. D. or other) 1
Address West Plains Date signed 4/20/40

1940
S-11158

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.....

Denver Roller

....., Registered Apprentice No.....

working under my personal supervision.

Signed

Denver Roller

Licensed Embalmer No. 4006

P. O. Address Mtn. Home, Arkansas

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

11158
State File No. 18591

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 384

Primary Registration District No. 5339

Registrar's No.

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

1. PLACE OF DEATH:

(a) County... Howell
(b) City or town... Spring Creek T. P.
(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... 40 yrs 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 w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife... Mary Jane Long 6. (c) Age of husband, or wife, if alive 69 year

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years 84 Months 6 Days 7 If less than one day _____ h _____ min.

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

10. Usual occupation... Farmed

11. Industry or business.

MOTHER FATHER { 12. Name Jane Long

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

14. Maiden name Diane Willard

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

16. (a) Informant Sheila Long

(b) Address Pattersonville Mo

17. (a) Burial (b) Date thereof. 4/29/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pattersonville Mo

18. (a) Signature of funeral director O. P. Mc Clare

(b) Address Gainesville Mo

19. (a) 5-13-40 (b) V. C. W. SIMONS
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURY (b) County Howell

(c) City or town Pattersonville MO
(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 1940 hour 12 minute 45 A.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 Heart failure Duration _____

Lobar Pneumonia

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

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) (e) Means of injury _____

23. Signature O. P. Sparks (M. D. or other) _____

Address West Plains Mo Date signed _____

1940

S-11158