

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **26176**

Registration District No. 773 Primary Registration District No. 6018A Registrar's No. 129

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Near Farmington
(c) Name of hospital or institution: State Hospital No. 4
(d) Length of stay: In hospital or institution 8 yr. 6 mo. 3 day
In this community 3 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(d) Street No. ?
(e) If foreign born, how long in U. S. A. 0 years.

3. (a) PRINT FULL NAME Harlan Long 520

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 Single

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Un. 1872
(Month) (Day) (Year)

8. AGE: Years 68 7/8 Months Un. Days Un. If less than one day _____ hr. _____ min.

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

10. Usual occupation Driver

11. Industry or business _____

MOTHER FATHER { 12. Name Geo. W. Long

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

14. Maiden name Unknown

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

16. (a) Informant Records of State Hospt. #4
(b) Address Farmington, Mo.

17. (a) Burial (b) Date thereof 7-6-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cemetery of State Hosp. #4

18. (a) Signature of funeral director Chas. Richardson
(b) Address Farmington, Mo.

19. (a) JS 5-40 (b) B. J. Robinson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 5 year 1940 hour 12 minute 25 A M.

21. I hereby certify that I attended the deceased from 7-11, 1939 to 7-5, 1940, that I last saw him alive on 7-4, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Duration 6 mo.

Due to Arteriosclerosis, generalized 2 yrs

Due to _____
Other conditions (include pregnancy within 3 months of death) A. J. O

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? 699

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

23. Signature Jas. R. Mulkey (M. D. or other) 1 mo
Address Farmington, Mo. Date signed _____

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

4

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..... Not embalmed.....

..... 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **26176**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **1773**

Primary Registration District No. **6018A**

Registrar's No.

1. PLACE OF DEATH

(a) County **St. Francois**
(b) City or town **St. Francois**
(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 **Harlan Long**

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

4. Sex **m** 5. Color **white** 6. (a) Single, widowed, married, divorced **S**

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 **68** Months **78** Days **?** If less than one day _____ min.

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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **Sept 5 1940** (b) **T. J. Robinson** (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 **7** day **5** 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 _____

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 _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTAL

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

St. Francois

