

NOV 19 1940

1. PLACE OF DEATH:

(a) County Chariton
(b) City or town Cockren Marceline Rural
(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 37 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME George Washington 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 widowed
6. (b) Name of husband or wife Susan Arneil Crawley 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 18 1871
(Month) (Day) (Year)

8. AGE: Years 89 Months 5 Days 21 If less than one day _____ hr. _____ min.

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

10. Usual occupation farmer

11. Industry or business _____

MOTHER FATHER
12. Name Richard Long
13. Birthplace Richmond Va.
(City, town, or county) (State or foreign country)
14. Maiden name Gabriella Gate
15. Birthplace Va.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature John H. Long
(b) Address Hamden Mo

17. (a) Burial (b) Date thereof Oct 11 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Coke Cemetery

18. (a) Signature of funeral director Jas. M. Langhorne
(b) Address Marceline Mo

19. (a) Oct 10 - 40 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Chariton
(c) City or town Marceline Rural
(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 Oct day 9 year 1940 hour 1 minute 30 P. M.

21. I hereby certify that I attended the deceased from Sept 20, 1940 to Oct 8, 1940 that I last saw no alive on Oct 8, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Nephritis Duration 1 yr

Due to _____

Due to 1/21

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

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? _____

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

23. Signature M. J. Billeto (M. D. or other) _____
Address Byramville Mo Date signed 10/19/40

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

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.

I X1811

RECEIVED
District Health Officer No. 8,
District File Number
11-13-40
Filed

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 Blanche Moughler
Licensed Embalmer No. 1908
P. O. Address Marceline Mo

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.