

Registration District No. **318**

Primary Registration District No. **2001**

I. PLACE OF DEATH:

GREENE

(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Baptist 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) _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limit, write "RURAL")
(d) Street No. Springfield, Rt. 3
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

3. (a) PRINT FULL NAME Clell Leon Long

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced Child
6. (b) Name of husband or wife Child 6. (c) Age of husband or wife if alive XX years
7. Birth date of deceased Dec. 6, 1940
(Month) (Day) (Year)

8. AGE: Years 10 Months 0 Days 0 If less than one day 7 hr. 30 min.

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

10. Usual occupation Child

11. Industry or business _____

12. Name Clellie Long
13. Birthplace Nichols, Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Opal Morrow (Long)
15. Birthplace Hartshorne, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Clellie Long
(b) Address Springfield, Rt.

17. (a) Burial (b) Date thereof 12-8-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Patterson (Cem.)

18. (a) Signature of funeral director Dunn Funeral Home
(b) Address Springfield

19. (a) 12-7-40 (b) W. E. Handley M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 6th
year 1940 hour 11 minute 30 P. M.

21. I hereby certify that I attended the deceased from Dec 6 -
1940 to Dec 6 1940
that I last saw him alive on Dec 6 1940
and that death occurred on the date and hour stated above.

Immediate cause of death maternal toxemia
Eclampsia with convulsions
& Hydramnias

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

Major findings: Of operations None
Of autopsy No

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 Joseph L. Johnston (M. D. or other)
Address Springfield, Mo. Date signed 12-7-40

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

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

39
3
6

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.....

..... 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.