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FILED APR 13 1942
Registration District No. 477

Primary Registration District No. 2002

Registrar's No. 100

1. PLACE OF DEATH:

(a) County **Jasper**
(b) City or town **Joplin**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Freeman Hosp.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 week.** (Specify whether
In this community **30 years** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jasper** 049
(c) City or town **Joplin** See
(If outside city or town limits, write "RURAL")
(d) Street No. **628, 1-2 Moffett Ave**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **No**

3. (a) PRINT FULL NAME

Maude M. Longacre.

3. (b) If veteran, name war. **no**

3. (c) Social Security No. **491-01-1728**

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **widow**
6. (b) Name of husband or wife **Hugh Longacre** 6. (c) Age of husband or wife if alive **years**
7. Birth date of deceased **Mar. 29, 1884**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
57 **11** **20** hr. min.

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

10. Usual occupation **housewife**
Tailoress

MOTHER FATHER
12. Name **Horace Lindsey**
13. Birthplace **Boston Mass;** (City, town or county) (State or foreign country)
14. Maiden name **Prudy Ann Riddle**
15. Birthplace **no record** (City, town, or county) (State or foreign country)

16. (a) Informant **Robert L. Longacre**
(b) Address **Joplin Mo;**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **3-23-42**
(Month) (Day) (Year)
(c) Place: burial or cremation **Ozark Mem. Cem.**

18. (a) Signature of funeral director **Hurlbut Und. Co;**
(b) Address **Joplin Mo;**

19. (a) **3-23-42** (Date received local registrar) (b) **Dutted Suskretter** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Mar. 20,** day **1942**
year. hour **11-30 A.M.** minute **M.**

21. I hereby certify that I attended the deceased from **March 6,** 19**42** to **March 20,** 19**42**
that I last saw her alive on **March 20,** 19**42**
and that death occurred on the date and hour stated above.

Immediate cause of death **Hypostatic Pneumonia**
Due to **Cerebral Hemorrhage**

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?

(Specify type of place)
While at work? (e) Means of injury
23. Signature **J. M. Gray** (M. D. or other)
Address **Joplin Mo** Date signed **3-21-42**

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 Steve L Parker

Licensed Embalmer No. 23748

P. O. Address Jefferson

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11042

Registration District No. 411

Primary Registration District No. 2002

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Joplin
(If outside city or town limits, state "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 Maudie M Longacre

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Mar 29 1914
(Month) (Day) (Year)

8. AGE: Years 57 Months 11 Days 20 (If less than one day, in 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 20
year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Mar 20 1942 to Mar 20 1942
that I last saw him alive on Mar 20 1942
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Poststatic Pneumonia
Bronchial

Due to 107

Other conditions Cerebral Hemorrhage
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy Hemorrhage from
Cereb. of Wallis

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 J M Gray M D (M. D. or other)

Address Joplin Mo Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-11041

1942