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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 21 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

26824

State File No.

Registration District No. 164 Primary Registration District No. 3008 Registrar's No. 218

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton O.T. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital No. 2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 yrs 1 M 22 d (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 14

(c) City or town Kansas City 1/2 (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.? 0 years.

3. (a) PRINT FULL NAME Mrs Sam Taylor Long

3. (b) If veteran, name war DK

3. (c) Social Security No. DK

4. Sex F 1

5. Color or race W

6. (a) Single, widowed, married, divorced Widowed 2

6. (b) Name of husband or wife David Long

6. (c) Age of husband or wife if alive Deceased years

7. Birth date of deceased May (Month) 15 (Day) 1890 (Year)

8. AGE: Years 52 Months 1 Days 29 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER

12. Name Thomas Ballard

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

14. Maiden name Lucinda Taylor

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

16. (a) Informant Record

(b) Address

17. (a) Burial Removal (Burial, cremation, or removal) (b) Date thereof July (Month) 14 (Day) 1942 (Year)

(c) Place: burial or cremation Richmond Mo

18. (a) Signature of funeral director Glen Y. Mumpin

(b) Address Fulton, Mo.

19. (a) 7-14-42 (Date received local registrar) (b) Josie Morsink Taff (Registrar's signature)

1141

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 14 year 1942 hour 15-30 minute a M.

21. I hereby certify that I attended the deceased from 7/14/ 1942, to 7/14/ 1942 that I last saw her alive on 7/13/ 1942 and that death occurred on the date and hour stated above.

Immediate cause of death acute cardiac dilatation Rt with extensive interstitial myocarditis

Due to [illegible]

Due to

Other conditions (Include pregnancy within 3 months of death) 95 c 4

Major findings:
Of operations

Of autopsy

Duration

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 George V. Reeves (M. D. or other) MD

Address Fulton Mo Date signed 7/14/42

(Licensed Embalmer's Statement on Reverse Side)

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 Glen H. Maupin

Licensed Embalmer No. 2725

P. O. Address Fulton, Mo.

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

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

. No. 2B
—8-21-41
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26824

Registration District No. 104 Primary Registration District No. 3008 Registrar's No.

1. PLACE OF DEATH:
(a) County: Callaway
(b) City or town: Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hosp no 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 7 yrs - 1 mo - 23 da (Specify whether
In this community: — — — years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Jackson
(c) City or town: Kansas City
(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

3. (a) PRINT FULL NAME: Mrs. Sam Taylor Long
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: May (Month) - 15 (Day) - 1890 (Year)

8. AGE: Years 52 Months 1 Days 29 If less than one day hr. min.

9. Birthplace (City, town, or county): (State or foreign country): Mo
10. Usual occupation:
11. Industry or business:

MOTHER FATHER
12. Name:
13. Birthplace (City, town, or county): (State or foreign country): Mo
14. Maiden name:
15. Birthplace (City, town, or county): (State or foreign country): Mo

16. (a) Informant:
(b) Address:
17. (a) (Burial, cremation, or removal): (b) Date thereof (Month) (Day) (Year):
(c) Place: burial or cremation:
18. (a) Signature of funeral director:
(b) Address:
19. (a) (Date received local registrar): (b) (Registrar's signature):

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 14 year 1942 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.

	Duration
Immediate cause of death: Acute Cardiac Dilitation Rt. with Extensive interstitial	
Due to: Myocarditis	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	93-C4
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: (M. D. or other)
Address: Date signed: M.D.

SUPPLEMENTARY