

FILED JAN 30 1943

State File No. _____

Registration District No. _____

Primary Registration District No. 3000

Registrar's No. 313

1. PLACE OF DEATH:

(a) County Adair
 (b) City or town Kirkville
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
802 S. Sheridan /
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community _____ Life years, months or days) (Specify whether

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair
 (c) City or town Kirkville
(If outside city or town limits, write "RURAL")
 (d) Street No. 802 S. Sheridan
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Susan Long

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

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

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

7. Birth date of deceased Oct. 23 1863
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>1</u>	<u>1</u>	hr. _____ min.

9. Birthplace Schuyler Co. Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Abner Fickle
 13. Birthplace Unknown (City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant James Reese
 (b) Address Kirkville, Mo.

17. (a) Burial (b) Date thereof 11-26-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mulberry Cemetery

18. (a) Signature of funeral director [Signature]
 (b) Address Kirkville, Mo.

19. (a) 11/30/42 (b) M. J. Wagon
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 24
 year 1942 hour 8:30 minute P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____
 that I last saw h_____ 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)

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) (a) Means of injury _____

23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

1044

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

NOV 5 1948

12-42-30 46

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 *D. W. Riley*

Licensed Embalmer No. *4181*

P. O. Address. *Hicksville ME*

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.

RECEIVED

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 1

Primary Registration District No. 3000

Registrar's No. 313

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Kirksville
(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 _____ (Specify whether
years, months or days) Life

3. (a) PRINT FULL NAME Susan 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 October 23 1865
(Month) (Day) (Year)

8. AGE: Years 79 Months 1 Days _____ If less than one day _____ min.

9. Birthplace Schuyler Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife
11. Industry or business Home

12. Name Abner Fickle

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

14. Maiden name Unknown

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

16. (a) Informant Kirksville, Missouri

17. (a) Burial (Burial, cremation, or removal) Mulberry Cemetery (b) Date thereof 11-26-42
(Month) (Day) (Year)

18. (a) Signature of funeral director Dee Ripley Riley (b) Address Kirksville, Missouri

19. (a) 11-30-42 (Date received local registrar) (b) Mrs. J. L. Wagner (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair
(c) City or town Kirksville
(If outside city or town limits, write "RURAL")
(d) Street No. 802 S. Sheridan
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November 24
year 1942 hour 8:30 minute _____ P. M.

21. I hereby certify that I attended the deceased from _____ 19 _____
that I last saw her alive on _____ 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of Stomach Duration _____

I hereby certify that I attended Susan Long from Oct. 28-42
to Nov. 21-42 and at that time she was in a semiconscious condition.

I did not see her after Nov. 21 1942 but I have no reason to doubt time of death.

Other conditions doubt time of death.
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN H. B. [Signature]
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 F. B. [Signature] (M.D. or other) _____
Address 227 N. Baker Date signed 12-17-42

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

SUPPLEMENTARY

1420

SEP 8 1949
FBI