. No. 2
—5-42
17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9542

State File No.

FILED APR 5 1943

Registration District No. 3006 Primary Registration District No. 3006 Registrar's No. 81

1. PLACE OF DEATH:
(a) County: Boone
(b) City or town: Columbia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Boone County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 10 Days (Specify whether years, months or days)
In this community: 38 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Boone
(c) City or town: Columbia
(If outside city or town limits, write "RURAL")
(d) Street No.: 1112 Grand Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: ZULA MAY LONG
3. (b) If veteran, name war: None
3. (c) Social Security No.: None
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Guy Long
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: 1 (Month) - 10 (Day) - 1905 (Year)
8. AGE: Years 38 Months 2 Days 19 If less than one day hr. min.
9. Birthplace: Boone County (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: At Home
11. Industry or business:
FATHER 12. Name: William McKissick
13. Birthplace: Michigan (State or foreign country)
MOTHER 14. Maiden name: Merkie Roberts
15. Birthplace: Boone County (City, town, or county) Missouri (State or foreign country)
16. (a) Informant: Guy Long
(b) Address: Columbia, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3-30-43 (Month) (Day) (Year)
(c) Place: burial or cremation: Memorial Park
18. (a) Signature of funeral director: Carter Funeral Service
(b) Address: Columbia, Mo.
19. (a) 3-30-43 (Date received local registrar) (b) Edna H. Barlow (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Mar. day: 29
year: 1943 hour: 9:00 minute: A. M.
21. I hereby certify that I attended the deceased from March 19th, 1943 to March 28, 1943 and that I last saw her alive on March 29, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Heart & Kidney Disease — Duration
Due to: Pneumonia
Due to: Influenza
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: Stephen D. Smith (M. D. or other)
Address: Columbia Date signed: 3/30/43

1250 (Licensed Embalmer's Statement on Reverse Side)

APR 5 194

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 W. D. Whitsides

Licensed Embalmer No. 3893

P. O. Address Calumet

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, fact should be so stated above.

. S. No. 2B
OM—8-21-41
I X29288

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. 9542

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 81

1. PLACE OF DEATH:

(a) County: Boone
(b) City or town: Columbia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Boone Co Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 days (Specify whether
In this community 38 yrs. years, months or days)

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 .....

3. (a) PRINT FULL NAME: Iola May 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: M
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: Jan. 10 (Month) 1904 (Day) (Year)

8. AGE: Years 38 Months 2 Days 10 If less than one day hr. min.

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

MOTHER FATHER
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) ..... (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 Mar. Day 9 year 1943 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.

Immediate cause of death: Heart failure Duration
Due to: Kidney disease Chronic
Due to: Pneumonia Bronchial
Due to: Influenza
Other conditions (Include pregnancy within 3 months of death) 131a
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 .....

SUPPLEMENTARY