S. No. 2
M—2-43
5-17-39
I X35

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

33859
State File No.

FILED NOV 1 1943

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4470

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town K. C. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1609 E. 18. 1 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Kansas (b) County Labette
(c) City or town Parsons (If outside city or town limits, write "RURAL")
(d) Street No. 2027 Cornney (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME MELVIN LONG Jr
3. (b) If veteran, name war no
3. (c) Social Security No. none
4. Sex Male
5. Color or race Negro
6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased May (Month) 12 (Day) 1924
8. AGE: Years 19 Months 5 Days 8 If less than one day hr. min.
9. Birthplace Kansas (City, town, or county) (State or foreign country)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name Melvin Long Sr
13. Birthplace Ark (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Lillian Wassick
15. Birthplace Navajo (City, town, or county) (State or foreign country)
16. (a) Informant Mr Melvin Long Sr
(b) Address 2027 Cornney Parsons
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/43 (Month) (Day) (Year)
(c) Place: burial or cremation Parsons Kans
18. (a) Signature of funeral director N B Moon
(b) Address 1820 E 18th St
19. (a) 10-21-43 (Date received local registrar) (b) T. E. Brown M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 20 year 1943 hour 4:00 minute a. m.
21. I hereby certify that I attended the deceased from Deputy to Coroner, 19..; that I last saw h.. alive on, 19..; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Homicide	
Gun shot wound of left chest	
Due to Thru Heart	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations —
Of autopsy yes

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) Homicide
(b) Date of occurrence 10-20-43
(c) Where did injury occur? K. C. (City or town) Jackson (County) Mo (State)
(d) Did injury occur in the home, on farm, in industrial place, in public place? In Street 1609-E-18 (Specify type of place)
While at work? (e) Means of injury Fire arms
23. Signature J. Richardson (M. D. or other)
Address 1832 Vine Date signed 10-21-43

(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.....

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, fact should be so stated above.