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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

14173

State File No.

Registrar's No.

FILED MAY 11 1944

1000

350

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County Bucyrus
(b) City or town St. Joseph
(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 1 1/2 mo 23 days
(Specify whether
In this community yes
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Holt
(c) City or town Maitland
(If outside city or town limits, write "RURAL")
(d) Street No. 1
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME

Dollie Long

(b) If veteran, name war

(c) Social Security No.

4. Sex Female

5. Color or race W.

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

6. (b) Name of husband or wife

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

7. Birth date of deceased

? (Month)

? (Day)

1903 (Year)

8. AGE:

Years 41

Months ?

Days ?

If less than one day

hr. min.

9. Birthplace

Holt Co Mo (City, town, or county) (State or foreign country)

10. Usual occupation

novice

11. Industry or business

MOTHER FATHER {

12. Name John Long

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

14. Maiden name Mary Randal

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

16. (a) Informant

Records Hospital

(b) Address

St. Joseph Mo

17. (a)

(Burial, cremation, or removal)

(b) Date there April 13 1944 (Month) (Day) (Year)

(c) Place: burial or cremation

Mound City

18. (a) Signature of funeral director

[Signature]

(b) Address

Mound City Mo

19. (a)

4-11-44 (Date received local registrar)

(b) [Signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 11 year 1944 hour 1 minute 9 A.M.

21. I hereby certify that I attended the deceased from 4-7 1944, to 4-11 1944 that I last saw her alive on 4-10 1944 and that death occurred on the date and hour stated above.

Immediate cause of death

Epilepsy

Duration

30 yrs

Due to

Due to

Other conditions

Potts Disease

(Include pregnancy within 3 months of death)

Major findings:

Of operations

16

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? _____

While at work? _____

(Specify type of place)

(e) Means of injury _____

23. Signature

[Signature] (M. D. or other)

Address St. Joseph Mo

Date signed 4-12-44

1233

(Licensed Embalmer's Statement on Reverse Side)

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: *W. Crawford*
Licensed Embalmer No. *1824*
P. O. Address: *Mound City Mo*

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.