

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

15174

Do not use this space.

MAY 9 1944

1. PLACE OF DEATH
 (a) County Mason Registration District No. 203
 (b) Township Lida Primary Registration District No. 4314
 (c) City Atlanta Mo. (d) Street No. _____ St. _____
 (e) Length of residence in city or town where death occurred (If death occurred in Hospital or Institution, write its name instead of street and number)
 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Eda Alice Long
 (a) Residence, No. _____ St. (If nonresident, give city or town and State) _____

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Joe Long
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4-28-1864
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
79 11 14

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-15-1944
 22. I HEREBY CERTIFY, That I attended deceased from March-26-1944 to April-9-1944
 I last saw him alive on April 9-1944 Death is said to have occurred on the date stated above, at 3:00 p.m.
 The principal cause of death and related causes of importance were as follows:

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. Retired
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

Myocarditis
 Date of onset (?)

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Gibbs Mo

Other contributory causes of importance:
Cerebral Arteriosclerosis

FATHER 13. NAME John B. Long

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

MOTHER 15. MAIDEN NAME Margaret Lee

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bermain Mo

17. INFORMANT (ADDRESS) George Long Atlanta Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE St. John's DATE 4-13-1944

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Embroidery Atlanta Mo

20. FILED April 15, 1944 Mrs. A. L. Cambre Local Registrar.

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____

(Signed) A. L. Cambre, M. D.
 (Address) Atlanta Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 10

District File Number 5-94-949

Date Filed MAY 8 1944

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,

H. M. Goodding, or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No. 175-0

P. O. Address Atlanta 7

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

If this body is not embalmed, above space should be left blank.