

1945  
3520

FILED MAR 18 1946

Registration District No. \_\_\_\_\_

Primary Registration District No. 4107

Registrar's No. 10

1. PLACE OF DEATH:

(a) County Cedar  
(b) City or town El Dorado Spg.  
(c) Name of hospital or institution: Kengle Home 1  
(d) Length of stay: In hospital or institution 65 years  
In this community 65 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cedar 20  
(c) City or town Jerico Spg. Mo  
(d) Street No \_\_\_\_\_  
(e) Citizen of foreign country? \_\_\_\_\_

3. (a) PRINT FULL NAME MARY-HELEN-LONG

3. (b) If veteran name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F race W 5. Color or race W 6. (a) Single, widowed, married divorced WID  
6. (b) Name of husband or wife DANIEL-J. LONG 6. (c) Age of husband or wife if alive 5 1870  
7. Birth date of deceased 8 (Month) 5 (Day) 1870 (Year)

8. AGE: Years 74 Months 5 Days 28 If less than one day hr. min.

9. Birthplace Kengle 1 (City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business \_\_\_\_\_  
12. Name MATHREW COLE  
13. Birthplace Kengle 1  
14. Maiden name SUSAN-WALKER  
15. Birthplace Kengle 1

16. (a) Informant Mrs W. J. Long  
(b) Address Jerico Spg. Mo  
17. (a) removal (b) Date thereof 2/8/45  
(c) Place: burial or cremation Buried in Jerico Spg.

18. (a) Signature of funeral director Mrs P. Long  
(b) Address Jerico Spg. Mo  
19. (a) 2/8/45 (b) J. J. Conway

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 3rd year 1945 hour 11 minute P. M.

21. I hereby certify that I attended the deceased from Feb 3 1945 to Feb 3 1945 that I last saw her alive on Feb 3 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes Mellitus

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) W

Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_

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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

23. Signature C. H. Underwood (M. D. or other) Do  
Address El Dorado Springs Date signed 2-8-45

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1046

RECEIVED

District Health Officer No. 7,

District File Number 2-45-178

Date Filed 3-12-42

*gashford no  
R. 1.*

**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 *Mr. D. Long*.....

Licensed Embalmer No. 3714

P. O. Address *Jones Sq. 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.