

S. No. 2  
M-8-43  
v. 5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

8689  
State-File No.

FILED MAR 20 1945

Registration District No.

Primary Registration District No. 1002

Registrar's No. 1241

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City, Mo  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: The Childrens Mercy Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 17 days  
(Specify whether years, months or days)

In this community 17 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Laclede 53

(c) City or town Lebanon  
(If outside city or town limits, write "RURAL")

(d) Street No. 302 S. Washington 2  
(If rural, give location)

(e) Citizen of foreign country? 1 (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME GARY Preston Long

3. (b) If veteran, name war mo

3. (c) Social Security No. mo

4. Sex M race W

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 May 27 1943  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

1 9 19 hr. min.

9. Birthplace Lebanon Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business

MOTHER FATHER

12. Name John Long

13. Birthplace Laclede Co. Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Myrtle McCay

15. Birthplace Dallas Co. Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant John Long  
(b) Address Lebanon Mo

17. (a) Removal (b) Date thereof Mar 16-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lebanon Mo

18. (a) Signature of funeral director Mrs CR Foster

(b) Address 918 Brooklyn

19. (a) 3-19-45 (b) I. G. Brown (123)  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 16  
year 1945 hour 6:30 minute A.M.

21. I hereby certify that I attended the deceased from February 28, 1945 to March 16, 1945 that I last saw him alive on March 16, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Meningocele  
Rupture of Rectum  
Rupture of bladder  
(Both due to growth of meningocele)

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Duration  
life  
15-20 days  
15-20 days

Major findings: 123  
Of operations  
Of autopsy: Meningocele, Rupture of Rectum  
Rupture of Bladder, Hydronephrosis

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 0

23. Signature Paul D. Kern, M.D. (M. D. or other)  
Address Mercy Hospital, K.C. Mo. Date signed 3-16-45

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

48  
3  
8

**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 Carlisle Minor

Licensed Embalmer No. 3414

P. O. Address 916 Brooklyn Rd

**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.**