S. No. 2
M—8-43
5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

23872

State File No. 0

FILED AUG 10 1945

Registration District No. ____ Primary Registration District No. 5423 Registrar's No. ____

1. PLACE OF DEATH:
(a) County Dunklin
(b) City or town Senath Mo Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Salem Twp
(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. USUAL RESIDENCE OF DECEASED: 35
(a) State Mo (b) County Dunklin
(c) City or town Senath
(If outside city or town limits, write "RURAL") 1
(d) Street No. ____
(If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME Oscar Long
3. (b) If veteran, name war ____
3. (c) Social Security No. 495 84 1945
4. Sex M 0
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Leona Long
6. (c) Age of husband or wife if alive 27 years
7. Birth date of deceased MARCH (Month) 30 (Day) 1894 (Year)
8. AGE: Years 51 Months 1 Days 8 If less than one day ____ hr. ____ min.
9. Birthplace NOT KNOWN (City, town, or county) 9 (State or foreign country)
10. Usual occupation FARMER
11. Industry or business ____
FATHER 12. Name NOT KNOWN
13. Birthplace NOT KNOWN (City, town, or county) 9 (State or foreign country)
MOTHER 14. Maiden name NOT KNOWN
15. Birthplace NOT KNOWN (City, town, or county) 0 (State or foreign country)
16. (a) Informant ____
(b) Address ____
17. (a) Burial (Burial, cremation, or removal) (b) Date then May-10-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Senath Cemetery
18. (a) Signature of funeral director McDaniel Funeral Service
(b) Address Senath Mo
19. (a) July-16-1945 (Date received local registrar) (b) H. O. Story (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 8 year 1945 hour 10 minute 30 M.
21. I hereby certify that I attended the deceased from ____, 19____, to ____, 19____; that I last saw h____ alive on ____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Lightning	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____
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: 35
(a) Accident, suicide, or homicide (specify) ____
(b) Date of occurrence ____
(c) Where did injury occur? Dunklin, Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ____ (Specify type of place)
While at work? yes (e) Means of injury 3
23. Signature Walter C. Hawkins M. D. or other Coroner
Address Kennett Mo Date signed 5-8-45

(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 Walter A Hawkins

Licensed Embalmer No. 2002

P. O. Address Kirkwood 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.

S. No. 2B
SM—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. ..... AUG 13 1945

Registration District No. 108 Primary Registration District No. 5423 Registrar's No. .....

1. PLACE OF DEATH:

(a) County Dunklin

(b) City or town Rural Salem Twp
(If outside city or town limits, write "RURAL" and name of township)

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

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

2. USUAL RESIDENCE OF DECEASED:

(a) State ..... (b) County .....

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

(d) Street No. ..... (If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Oscar Long

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife .....

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

7. Birth date of deceased Mar (Month) 30 (Day) 1894 (Year)

8. AGE: Years 51 Months 1 Days 8 If less than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) N.K. (State or foreign country)

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)

16. (a) Informant .....
(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....
(b) Address .....

19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Mar day 8
year 1945 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... , 19..., to ..... , 19.....;
that I last saw h..... alive on ..... , 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death .....

Due to .....

Due to .....

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

Major findings:
Of operations .....

Of autopsy .....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

187-8
19

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence May 8th 1945

(c) Where did injury occur? Kennett (City or town) Rural (County) Dunklin (State) MO

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
on Farm coming in out of a starm
(Specify type of place)

While at work? yes (e) Means of injury Lighting

23. Signature Walter G. Hawkins (M. D. or other) Car

Address Kennett MO Date signed 8-14-45

SUPPLEMENTARY

23872