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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

FILED NOV 9 1945 STANDARD CERTIFICATE OF DEATH

State File No. 33339

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 3035

1. PLACE OF DEATH:
(a) County Calloway
(b) City or town Fulton (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mo State Hospital #1 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3-16-45 (Specify whether years, months or days)
In this community 6 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Jackson
(c) City or town Kansas City (If outside city or town limits, write "RURAL")
(d) Street No. Jackson Co. Home (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME James W. Long
3. (b) If veteran, name war no
3. (c) Social Security No. no

4. Sex Male
5. Color or race Negro
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Mary E. Long
6. (c) Age of husband or wife if alive 75 years
7. Birth date of deceased 10 (Month) 15 (Day) 1866 (Year)

8. AGE: Years 78 Months 11 Days 8 If less than one day ... hr. ... min.

9. Birthplace Shawnee (City, town, or county) Kansas (State or foreign country)
10. Usual occupation Minister of the Gospel
11. Industry or business

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

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

16. (a) Informant Christina Neal
(b) Address 2448 Chestnut St. K.C. Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct 7-45 (Month) (Day) (Year)
(c) Place: burial or cremation Woodlawn K.C. Kansas
18. (a) Signature of funeral director K.C. Bur. & Caskets Co. Moses J. W. Jones
(b) Address 440 State Ave K.C. Kan.
19. (a) Oct 7-1945 (Date received local registrar) (b) Josie Moraueckoff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 23 year 1945 hour 11 minute 15 A M.

21. I hereby certify that I attended the deceased from 3-16, 1945 to 9-23, 1945
that I last saw him alive on 9-23, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Encephalo malacia, multiple foci — Duration

Due to

Due to

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Other conditions Generalized arterio sclerosis and active Pulmonary T.B. with cerebral
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy above mentioned and also advanced degeneration, arteriosclerotic nephritis

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature K. E. Sherrell per P. S. Toms (M. D. or other)
Address State Hosp. # 1 Date signed 9-26-45

1147

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No.

District File Number 47

Date Filed 11-8-45

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 Eugene English

Licensed Embalmer No. 4513

P.O. Address 440 State

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

If this body is not embalmed, fact should be so stated above.

No. 2B
—5-43
I X36930

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 11 01

Registration District No. 47 — Primary Registration District No. 3008 — Registrar's No. 305

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

1. PLACE OF DEATH:
(a) County Callaway
(b) City or town (If outside city or town limits, write "RURAL" and name of township) 2
(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 years, months or days)
In this community

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 James W. Long
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race B
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 Oct (Month) 15 (Day) (Year)

8. AGE: Years 78 | Months 11 | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) Kansas (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)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day 23
year 1940 hour minute M.

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

	Duration
Immediate cause of death	
Due to Chronic Bronchopneumonia	
Due to Senility	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy 13 h	

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature T. E. Stamper 9/13/40 (M. D. or other)
Address Date signed

33339