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7.5-17-39  
X35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34657

State File No. \_\_\_\_\_

Registrar's No. 2419

FILED OCT 22 1945  
Registration District No. 367

Primary Registration District No. 3063

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: St. Louis County Hospital  
(If not in hospital or institution, write street number and location)

(d) Length of stay: In hospital or institution 8 days  
(Specify whether years, months or days)

In this community 10 yrs  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96

(c) City or town Florissant 10  
(If outside city or town limits, write "RURAL")

(d) Street No. Shackleford Road 0  
(If rural, give location)

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

3. (a) PRINT FULL NAME CHARLES LONG

(b) If veteran, name war no

(c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 16 1945  
year 1945 hour 7:20 minute \_\_\_\_\_ P.M.

4. Sex Male 5. Color or race Wh.

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

(b) Name of husband or wife Sarah Calhoon

(c) Age of husband or wife if alive 66 years

7. Birth date of deceased: April 12 1879  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct. 8, 1945 to Oct. 16 1945.  
that I last saw him alive on Oct. 16 1945.  
and that death occurred on the date and hour stated above.

8. AGE: Years 66 Months 6 Days 4  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death: Carcinoma of rectum  
metastasis  
46d.

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

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

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

10. Usual occupation None

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.

11. Industry or business \_\_\_\_\_

MOTHER FATHER } 12. Name Fred Long

13. Birthplace Germany  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Jane Petty  
(City, town, or county) (State or foreign country)

15. Birthplace U.S.  
(City, town, or county) (State or foreign country)

16. (a) Informant Son, William Long

(b) Address Shackleford Rd., Florissant, MO

17. (a) BURIAL (b) Date thereof 10-19-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Charles, Mo

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? \_\_\_\_\_

18. (a) Signature of funeral director Charles J. Hogue

(b) Address 4700 Washington Blvd

19. (a) 10-19-45 (b) E. J. McManis  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_  
(Specify type of place)

(c) Means of injury D

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address 661 Brentwood Date signed 10-18-45

APR 21 1965

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**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 Robert G. Hays

Licensed Embalmer No. 2951

P. O. Address.....

**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.**