

FILED DEC 7 1945

Registration District No. 42

Primary Registration District No. 1000

Registrar's No.

1. PLACE OF DEATH:

(a) County Bushong
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri Methodist Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether years, months or days)
In this community 30 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Bushong
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 113 Buffalo
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country no 3 dy

3. (a) PRINT FULL NAME Jennie Long

3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex F 3 5. Color or race negro 6. (a) Single, widowed, married, divorced widowed
7. Birth date of deceased Nov 12 1884
(Month) (Day) (Year)
8. AGE: Years 61 Months 00 Days 8 If less than one day hr. min.
9. Birthplace Missouri (City, town, or county) (State or foreign country)
10. Usual occupation Domestic
11. Industry or business none
12. Name unknown
13. Birthplace unknown (City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown (City, town, or county) (State or foreign country)
16. (a) Informant Hospital Record
(b) Address St. Joseph
17. (a) Burial (b) Date thereof 11-23-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Ashland Cemetery
18. (a) Signature of funeral director Ramsey & Son
(b) Address 1602 Meador
19. (a) Nov 29 1945 (b) W. Nestlebus
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 20 year 1945 hour 1 minute 20 P.M.
21. I hereby certify that I attended the deceased from November 19 1945 to November 20 1945 that I last saw H.E.R. alive on November 20 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Congestion

Due to Chronic Myocarditis

Due to

Other conditions Possible CA of ovary
(Include pregnancy within 3 months of death)
Chr. Arthritis

Major findings: Of operations None

Of autopsy None

Duration

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) no
(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 W. J. Jacobshaus (M. D. or other) M.D.
Address Social Welfare Board Date signed 11/20/45

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

MOTHER FATHER

REC'D

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..... *L. F. Ramsey*

Licensed Embalmer No. *4081*

P. O. Address *1602 Melloniz*

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.