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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

3739

FILED FEB 14 1946
Registration District No. 290
276

Primary Registration District No. 5983
5255

State File No. _____
Registrar's No. 17

1. PLACE OF DEATH:

(a) County Pulaski

(b) City or town Ft Leonard Wood, Missouri

(c) Name of hospital or institution:
Regional Station Hospital, Ft L Wood, Mo.
(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 6 months - 5 days

2. USUAL RESIDENCE OF DECEASED:

(a) State South Carolina (b) County Richland 999

(c) City or town Columbia
(If outside city or town limits, write "RURAL") 30

(d) Street No. 711 Assembly Street
(If rural, give location) 1

(e) Citizen of foreign country? No (Yes or No) 2

If yes, name country _____

3. (a) PRINT FULL NAME Frank Long

3. (b) If veteran, name war _____

3. (c) Social Security No. unknown

4. Sex Male 2

5. Color or race Negro

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 July 5 1917
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>28</u>	<u>5</u>	<u>27</u>	hr. _____ min.

9. Birthplace Columbia South Carolina
(City, town, or county) (State or foreign country)

10. Usual occupation Soldier - U S Army - 44092433

11. Industry or business Pvt - Co D, 34th ET Bn, ASFTC

MOTHER FATHER

12. Name Unknown

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

14. Maiden name Ida Long

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

16. (a) Informant U. S. Army Records

(b) Address Ft Leonard Wood, Missouri.

17. (a) Removal (b) Date thereof Jan 4 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbia, S.C.

18. (a) Signature of funeral director Smith-Halloran

(b) Address Roca, Mo.

19. (a) 3 Jan 1946 (b) Smith-Halloran
(Date received local registrar) (Registrar's signature)

Jan 15, 1946 265 Mrs. Juanita
(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 2
year 1946 hour 5 minute 20 P.M.

21. I hereby certify that I attended the deceased from _____, 19____, to January 2, 1946;
that I last saw him alive on January 2, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death (1) Asphyxiation

Duration _____

Due to (cause other than trauma)
(2) Edema, pulmonary, due to undetermined
cause, (3) Avulsion of soft tissue
of distal phalanx of left index
finger.

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

Major findings:
Of operations _____

Of autopsy AS above.

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? 65

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

23. Signature Corde Rose, Capt. MC (M. D. or other) H.D.

Address Ft. L. Wood, Mo. Date signed Jan 15 1946

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

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.....

J. J. Saccan

Licensed Embalmer No. *3643*

P. O. Address *Rolla, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3789

Registration District No. 290

Primary Registration District No. 5983

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Pulaski
(b) City or town Leonard Wood
(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

3. (a) PRINT FULL NAME Frank 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 S

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

7. Birth date of deceased July (Month) 5 (Day) 1918 (Year)

8. AGE: Years 28 Months _____ Days _____ If less than one day hr. _____ min. _____

9. Birthplace _____ (City, town, or county) _____ (State or foreign country) S.C.

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions _____
(Includes 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:

(a) Accident, suicide, or homicide (specify) Accident L
(b) Date of occurrence 2 January 1946 L
(c) Where did injury occur? Ft. Leonard Wood, Pulaski Mo. L
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In hospital

While at work? No (Specify type of place) (e) Means of injury Anesthetic death

23. Signature Corde Rose Capt. U.S. M.D. (M. D. or other) _____
Address 767 Summit Ave, River Edge, N.J. Date signed 22 March 1946

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

1836

SUPPLEMENTARY

