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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 15 1946
Registration District No. 120

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
Primary Registration District No. 4194

State File No. 9042
Registrar's No. 31

1. PLACE OF DEATH:
(a) County Lentz
(b) City or town Alfany mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None (Specify whether)
In this community 4 yrs
years, months or days

3. (a) PRINT FULL NAME JOHN NORMAN 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 divorced
6. (b) Name of husband or wife Lou Hannah Long 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased March 19 1864
(Month) (Day) (Year)

8. AGE: Years 81 Months 11 Days 29 If less than one day
hr. _____ min. _____

9. Birthplace Lentz mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Wm Long

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

14. Maiden name Florence Jane Crane

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

16. (a) Informant Mr Paul Murray

(b) Address Alfany mo

17. (a) Burial (b) Date thereof 3 20 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Miller Cemetery

18. (a) Signature of funeral director Paul Mott

(b) Address Denver mo
March 20 1946 (Date received local registrar) (b) Thomas M. Mott (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State mo (b) County Lentz 38
(c) City or town Alfany mo 1
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 2
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 18
year 1946 hour 6 minute _____ P. M.

21. I hereby certify that I attended the deceased from July 15th 1945 to March 18th 1946
that I last saw him _____ alive on _____ 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of throat and larynx
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

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

23. Signature W. S. Campbell (M. D. or other)
Address Alfany mo Date signed March 20 1946

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

103

(Licensed Embalmer's Statement on Reverse Side)

1446

DISTRICT HEALTH OFFICE
Cameron, Mo.

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.P. Brown

Licensed Embalmer No. *2947*

P. O. Address.....

J.P. Brown

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. April

Registrar's No. 31

Registration District No. 120

Primary Registration District No. 4194

1. PLACE OF DEATH:

(a) County Gentry
(b) City or town Albany
(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

John N. 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 wid

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

7. Birth date of deceased mar 19
(Month) (Day) (Year)

8. AGE: Years 81 Months 11 Days _____ (If less than one day) _____ hr. _____ min.

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

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(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 _____
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 _____

Due to the front part of the lower jaw?
Due to _____

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

Major findings: _____
Of operations _____

Of autopsy _____

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?

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

23. Signature _____ (M, D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

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

7970

PHYSICIAN
Underline the cause to which death should be charged statistically.

9042