

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7430 /
State File No. _____
Registrar's No. 489

FILED MAR 31 1947

Registration District No. 37

Primary Registration District No. 6076

Registrar's No. 489

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
6100 Grimshaw Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 26 Years
years, months or days)

3. (a) PRINT FULL NAME JOHN JOSEPH LONG

3. (b) If veteran, name war World War # 1

3. (c) Social Security No. 489-03-9826

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Augusta

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased Jan. 15, 1894
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>53</u>	<u>1</u>	<u>23</u>	hr. _____ min. _____

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Foreman

11. Industry or business Acme Rug cleaning Co.

MOTHER FATHER

12. Name John Long

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

14. Maiden name Helen Buckley

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

16. (a) Informant Augusta Grimshaw Long

(b) Address 6100 Grimshaw Ave.

17. (a) Burial (b) Date thereof 13-10-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director Cullen + Kelly

(b) Address 4386 Lindell Blvd

19. (a) 3-10-47 (b) Ruth J. Cullen
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town Pine Lawn
(If outside city or town limits, write "RURAL")

(d) Street No. 6100 Grimshaw Ave.
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 7
year 1947 hour 12 minute 30 M.
noon

21. I hereby certify that I attended the deceased from
March 6, 1947, to March 7, 1947
that I last saw him alive on March 7, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death
Acute Myocarditis with
Coronary Congestion
Due to Septicemia & Pneumonia
Diphtheria type at lower lobes

Due to _____

Other conditions
(Include pregnancy within 3 months of death)

93d

PHYSICIAN

Major findings:
Of operations: _____

Of autopsy NO

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? _____

While at work? _____ (Specify type of place)

Signature Subert Timm (M. D. or other) _____

Address 3734 Jennings Rd. Date signed _____

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

76
0
0

APR 16 1947

APR 22 1947

APR 7 1947

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 Albert Mayfield

Licensed Embalmer No. 3079

P. O. Address St. Louis

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.