

FILED MAY 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18394

State File No. 4254

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	2109
d. FULL NAME OF HOSPITAL OR INSTITUTION 4440 Farlin Ave.		d. STREET ADDRESS (If rural, give location) 4440 Farlin Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) Johanna b. (Middle) A. c. (Last) Long			4. DATE OF DEATH (Month) (Day) (Year) May 8, 1950			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Oct. 28, 1900	9. AGE (In years last birthday) 49	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.	

13a. FATHER'S NAME Patrick Kehoe		13b. MOTHER'S MAIDEN NAME Anastia Duffy		14. NAME OF HUSBAND OR WIFE Robert L. Long	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Margaret Long, 4440 Farlin Ave.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH 14 yrs
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____		Brain tumor			
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
		DUE TO (b) _____			
		DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Malignant (supp report)			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **10-27-1948** to **5-8-1950** that I last saw the deceased alive on **5-8-1950** and that death occurred at **7:30 p. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J. B. Fasater		23b. ADDRESS 4110 W. Brentan		23c. DATE SIGNED 5-10-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 5-12-50		24c. NAME OF CEMETERY OR CREMATORY National Cemetery	
DATE REC'D BY LOCAL REG. MAY 11 1950		REGISTRAR'S SIGNATURE J. B. Fasater		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Harrigan-Sheahan, 4700 Washington Blvd	

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

40 8824

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Elmer R. Paulwell

Licensed Embalmer No. _____

4077

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.