

FILED OCT 5 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32214**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **6076** Registrar's No. **2173**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) Manchester	c. LENGTH OF STAY (in this place) 1 yr - 7 mo	c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 211.9	
d. FULL NAME OF HOSPITAL OR INSTITUTION Pine Crest Nursing Home		d. STREET ADDRESS (If rural, give location) 3225 Montgomery St	

3. NAME OF DECEASED (Type or Print) MANOEL	a. (First)	b. (Middle)	c. (Last) LONG.	4. DATE OF DEATH (Month) (Day) (Year) SEPT 8 - 1950
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 9	8. DATE OF BIRTH April 25 - 1871	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months 4 Days 15	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown	10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? US		

13a. FATHER'S NAME Manuel Long	13b. MOTHER'S MAIDEN NAME Lege Benson	14. NAME OF HUSBAND OR WIFE Unknown
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year of dates of service) no	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Pine Crest Nursing Home	ADDRESS _____
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis		INTERVAL BETWEEN ONSET AND DEATH 4.22
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio Sclerosis		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Nephritis		

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION 4.22	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **9-1**, 19**50**, to **9-8**, 19**50**, that I last saw the deceased alive on **9-8**, 19**50**, and that death occurred at **8 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE R. H. Jansen M.D.	(Degree or title)	23b. ADDRESS 4401 Ca 16th + Locust St	23c. DATE SIGNED 9/9/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removed to	24b. DATE 9-12-50	24c. NAME OF CEMETERY OR CREMATORY Anthonies Woods	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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DATE REC'D BY LOCAL REG. SEP 13 1950	REGISTRAR'S SIGNATURE Herbert R. Donker M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc.	ADDRESS 4104 Manchester Ave., St. Louis 10, Mo.
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WRITE PLAINLY—USING 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.....

..... Student Embalmer No.

working under my personal supervision.

Student

Student Embalmer.

Signed.....

Licensed Embalmer No.....

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.