

No. 300  
10.48

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THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Dr. ~~J. Williams~~  
State File No. 12329  
Registrar's No. 5465

396  
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| BIRTH NO. _____   |  | REG. DIST. NO. <u>128</u>   |  | PRIMARY REG. DIST. NO. <u>5465</u>                          |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Greene</u>  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u> |   |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield, Rural North Campbell Twp</u>   |  | c. LENGTH OF STAY (In this place) <u>Life</u>                                     | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield (Rural North Campbell Twp)</u>                 |   |  |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Route # 6 Bodine St.</u>  |  |   | d. STREET ADDRESS (If rural, give location) <u>Route # 6 Bodine, St.</u>   |   |  |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Leona</u>   |  | b. (Middle) _____   | c. (Last) <u>Long</u>  | 4. DATE OF DEATH (Month) (Day) (Year) <u>April 20, 1951</u> |  |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>             | 8. DATE OF BIRTH <u>Sept. 7 1916</u>   | 9. AGE (In years last birthday) <u>34</u>                   | IF UNDER 1 YEAR Months _____ Days _____  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>  | 11. BIRTHPLACE (State or foreign country) <u>Springfield, Mo.</u>                 |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>                     |  |
| 13a. FATHER'S NAME <u>Jake Quehl</u>  |  | 13b. MOTHER'S MAIDEN NAME <u>Stella Boyce</u>                                     |  | 14. NAME OF HUSBAND OR WIFE <u>Charles W. Long</u>          |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   | 16. SOCIAL SECURITY NO. <u>No.</u>   | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Charles W. Long Springfield, Mo.</u> |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.                              | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Encephalitis - ac</u><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Acute Injurious abscess - bilateral</u><br><br>DUE TO (c) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <u>Mental defective - med.</u> |   |  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| 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) _____  |   |  |
| 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 21f. HOW DID INJURY OCCUR _____  |   |  |   |  |
| 22. I hereby certify that I attended the deceased from <u>4-17, 1951</u> , to <u>4-20, 1951</u> , that I last saw the deceased alive on <u>4-18, 1951</u> , and that death occurred at <u>7:05 a.m.</u> , from the causes and on the date stated above. |  |   |  |   |  |
| 23a. SIGNATURE <u>John Williams</u> (Degree or title) <u>M.D.</u>   |  |   | 23b. ADDRESS <u>710 Landon Bld Springfield</u>   |   | 23c. DATE SIGNED <u>4-21-51</u>  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 24b. DATE <u>4/23/51</u>   | 24c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn</u>                               | 24d. LOCATION (City, town, or county) (State) <u>Springfield, Mo.</u>  |   |  |
| DATE REC'D BY LOCAL REG. <u>4-23-51</u>   | REGISTRAR'S SIGNATURE <u>W.E. Landry</u>   |   | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>H.H. Lohmeyer Springfield, Mo.</u>   |   |  |

(Printed Embosser's Statement on Reverse Side)

RECEIVED

Greene County Health Office,

County File Number... 51-4-24

Date Filed 4/23/51

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

*Lester T. Swadley*

Licensed Embalmer No. 4815

P. O. Address Springfield

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.