

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26832

State File No. ....

FILED AUG 16 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 175 PRIMARY REG. DIST. NO. 3036 Registrar's No. 63

1. PLACE OF DEATH a. COUNTY <u>Lawrence County</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Missouri</u> b. COUNTY <u>Lawrence</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Aurora</u>		c. CITY OR TOWN <u>Route 1 Marionville</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (In this place) <u>4 weeks</u>		e. STREET ADDRESS (If rural, give location) <u>Route 1</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Aurora Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Quigley</u>	b. (Middle) <u>Lafayette</u>	c. (Last) <u>Long</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>August 7, 1955</u>
-------------------------------------	---------------------------	------------------------------	-----------------------	---

5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>July 30, 1877</u>	9. AGE (In years last birthday) <u>78</u>	IF UNDER 1 YEAR Months <u>8</u>	IF UNDER 24 HRS. Hours <u></u>	IF UNDER 1 MIN. Mins. <u></u>
--------------------	-------------------------------	---	---------------------------------------	---	---------------------------------	--------------------------------	-------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>Barry Co. Monett, R., Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
---	-----------------------------------	---	--

13a. FATHER'S NAME <u>George Long</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah Smith</u>	14. NAME OF HUSBAND OR WIFE <u>Lucretia Long</u>
---------------------------------------	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Quigley Long</u>	ADDRESS <u>Rural Marionville Mo</u>
--	-----------------------------------	--	-------------------------------------

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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypostatic pneumonia</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cardio Vasc. Accident</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing 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) (Min.)	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 July 31, 1955, to Aug 7, 1955, that I last saw the deceased alive on Aug 7, 1955, and that death occurred at 9:20 p. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Dr. McCallister M.D.</u>	23b. ADDRESS <u>20 W. Main Street, Marionville, Mo.</u>	23c. DATE SIGNED <u>Aug 8, 1955</u>
--	---	-------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Aug. 10, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Marionville, Mo.</u>
---	--------------------------------	--	---

DATE REC'D BY LOCAL REG. <u>8/9/1955</u>	REGISTRAR'S SIGNATURE <u>Orsa Mc Natt</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Sturridge</u>	ADDRESS <u>Marionville, Mo.</u>
--	---	---	---------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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.....  
Signature of Student Embalmer

Signed *Herman Turridg*

Licensed Embalmer No. *30*

P. O. Address *Marion*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.