

FILED JAN 3 - 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40297

410

BIRTH NO. _____ REG. DIST. NO. 133 PRIMARY REG. DIST. NO. 5490 Registrar's No. 22

1. PLACE OF DEATH a. COUNTY Harrison		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Harrison	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural		c. LENGTH OF STAY (in this place) lifetime	c. CITY OR TOWN
d. FULL NAME OF HOSPITAL OR INSTITUTION rural south of New Hampton		e. STREET ADDRESS (If rural, give location) rural (south of New Hampton) 0410	
3. NAME OF DECEASED (Type or Print) a. (First) Susan		b. (Middle) S mith	c. (Last) Long
4. DATE OF DEATH Dec 27, 1955		5. SEX F	
6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Sept 11, 1868
9. AGE (In years last birthday) 87		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	11. BIRTHPLACE (City and State or Foreign Country) Gentry County, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Samuel McKillen	13b. MOTHER'S MAIDEN NAME Piney Shackelford
14. NAME OF HUSBAND OR WIFE Lennie 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 Nellie Neese		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.	19. DATE OF OPERATION
MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary thrombosis		INTERVAL BETWEEN ONSET AND DEATH 2 days	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Agedity		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4201	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 Nov. 1, 1955, to Dec 22, 1955, that I last saw the deceased alive on Dec 22, 1955, and that death occurred at 4:30 p.m., from the causes and on the date stated above.
23a. SIGNATURE C. J. Pray, D.O.		23b. ADDRESS (Degree or title) Albany, MO.	23c. DATE SIGNED 12-30-55
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE Dec 29, 1955	24c. NAME OF CEMETERY OR CREMATORY Foster
24d. LOCATION (City, town, or county) (State) Harrison Co. Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Zola Burris	ADDRESS Albany Mo
DATE REC'D BY LOCAL REG. 12/31/55		REGISTRAR'S SIGNATURE	116-

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^{me}....., Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Robert Brink
Licensed Embalmer No....3329.

P. O. Address Albany, Mo.

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.