Health, Welfare Public Service

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1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED JUN 10 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16751
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 523

1. PLACE OF DEATH
a. COUNTY Greene
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield — Inside Limits Yes X No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. John's Hosp. — Length of stay in 1b 5 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Greene
c. CITY OR TOWN Springfield — Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location) 856 S. Douglas — Reside on Farm Yes ☐ No X

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3. NAME OF DECEASED (Type or print) First Owen Middle Last Long
4. DATE OF DEATH Month June Day Year 4-1957
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED X DIVORCED ☐
8. DATE OF BIRTH Aug. 26, 1881
9. AGE (In years last birthday) 75 — 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) Night Watchman
10b. KIND OF BUSINESS OR INDUSTRY Quarry
11. BIRTHPLACE (City and state or country) Warren County, Ken.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Bill Long
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ----------
16. SOCIAL SECURITY NO.
17. INFORMANT Address Cecil Long-Springfield, Missouri.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH 2 wks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ____ DUE TO (c) ____ 332.X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑ 2
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 1950, to 6-4-57 and last saw ~~her~~ him alive on 6-4-57
Death occurred at 10:05 a. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) G B Lemmon Jr. 0
22b. ADDRESS Springfield, Mo
22c. DATE SIGNED 6-5-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE June 7-'57
23c. NAME OF CEMETERY OR CREMATORY Ash Grove Cemetery
23d. LOCATION (City, town, or county) (State) Ash Grove, Missouri.

24. FUNERAL DIRECTOR ADDRESS Rex Davis Springfield
25. DATE RECD. BY LOCAL REG. 6-7-57
26. REGISTRAR'S SIGNATURE Edith Williamson

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 3312

P. O. Address Springfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.