

FILED OCT 14 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31026

STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 248

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE <u>Mo.</u> b. COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Fulton</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Callaway Hosp</u>	Length of stay in lb <u>5 Mo.</u>	d. STREET ADDRESS (If outside, give location) <u>511 Grand</u>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Doyle</u> Last <u>Long</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>10</u> Year <u>1957</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/28/1897</u>		9. AGE (In years last birthday) <u>60</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hospital Attendant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hosp.</u>	11. BIRTHPLACE (City and state or country) <u>Roone Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>R.L. Long</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Wilhite</u>	14. NAME OF HUSBAND OR WIFE <u>Mrs Ernest 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>495-40-9157</u>	17. INFORMANT <u>Mrs Ernest Long</u>	Address <u>Fulton Mo</u>
--	--	---	-----------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of left eye</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Injury by foreign body</u> DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <u>192X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	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 Aug. 1952 to Oct. 1957 and last saw ^{her} _{him} alive on Oct. 10, 1957
Death occurred at 3:00 a. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>E. A. Seivres</u>	(Degree or title) <u>D.O.</u>	22b. ADDRESS <u>Fulton, Mo.</u>	22c. DATE SIGNED <u>10/11/57</u>
--	----------------------------------	------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10/11/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Callaway Mem. Gardens</u>	23d. LOCATION (City, town, or county) (State) <u>Fulton Mo.</u>
--	------------------------------	--	--

24. FUNERAL DIRECTOR <u>Maapin</u>	ADDRESS <u>Fulton Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Oct. 12 - 1957</u>	26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>
---------------------------------------	------------------------------	---	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Leuris

PAID
APR 30 1958

JAN 29 1958

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 *J. J. Passon*

Licensed Embalmer No. *9155*

P. O. Address *Fullon*

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.