

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032730

FILED VS OCT 2 1959

Registration District No. 154 Primary Registration District No. 5575 Registrar's No. 36

STATE FILE NUMBER

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|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>JACKSON</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY <u>JACKSON</u> | |
| b. CITY (If outside of town, give town or township) OR TOWN <u>HICKMAN Mills</u> | | c. CITY OR TOWN <u>HICKMAN Mills</u> | |
| Length of stay in 1b <u>65 YRS</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>11418 JACKSON</u> | | d. STREET ADDRESS (If outside, give location) <u>11418 JACKSON</u> | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|---|----------------------------------|---|--|--|---|
| 3. NAME OF DECEASED (Type or print) First <u>STELLA</u> Middle <u>ARVELLA</u> Last <u>LONG</u> | | | 4. DATE OF DEATH Month <u>Sept</u> Day <u>25</u> Year <u>1959</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-22-1883</u> | 9. AGE (last birthday) <u>76</u> | IF UNDER 1 YEAR Months Days Hours Min. |
| 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 (City and state or country) <u>Montrose Missouri</u> | |
| 12. CITIZEN OF WHAT COUNTRY <u>US.</u> | | 13a. FATHER'S NAME <u>Albert Rowan</u> | | 13b. MOTHER'S MAIDEN NAME <u>Eliza Custer</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) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | |
| 17. INFORMANT <u>Robert Long</u> | | 18. ADDRESS <u>11418 JACKSON</u> | | | |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> | | | <u>10 days</u> | | |
| DUE TO (b) <u>Cerebral arteriosclerosis</u> | | | <u>5 yrs</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>Chronic rheumatoid arthritis</u> | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | |

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|---|---|--|--|--------|-------|
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 Month, Day, Year a.m. p.m. | | | | | |
| 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 <u>12/2/52</u> to _____ and last saw her <u>alive</u> on <u>9/21/59</u> Death occurred at <u>2 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |

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| 22. SIGNATURE (Degree or title) <u>Claude J. O'Neil M.D.</u> | | 22b. ADDRESS <u>4526 Paces</u> | | 22c. DATE SIGNED | |
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>Sept 26-1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill</u> | | 23d. LOCATION (City, town, or county) (State) <u>KANSAS City Missouri</u> | |
| 24. FUNERAL DIRECTOR <u>Wates F. H.</u> | | ADDRESS <u>1901 Olive Blvd. Kansas City 3, Mo</u> | | 25. DATE RECD. BY LOCAL REG. <u>19/25/59</u> | |
| | | | | 26. REGISTRAR'S SIGNATURE <u>Paul G. O'Quinn</u> | |

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT BY AFFIDAVIT OF CLAUDE J. O'NEIL, M.D. MEDICAL CERTIFICATION

OCT 2 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Paul R. Williamson

Licensed Embalmer No. 5009

P. O. Address Overland Park, 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.