

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035666

FILED VS OCT 20 1959

ENDED

Registration District No. 098 Primary Registration District No. _____ Registrar's No. 86 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Daviess</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Gallatin</u> Length of stay in lb <u>16 Yrs.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>---</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Daviess</u> c. CITY OR TOWN <u>Gallatin</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>---</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Otto</u> Middle <u>Emerson</u> Last <u>Long</u>			4. DATE OF DEATH Month <u>October</u> Day <u>15</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>1-10-1883</u>	9. AGE (last birthday) <u>76</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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 <u>Farm Owner</u>		11. BIRTHPLACE (City and state or country) <u>Keokuk Co., Iowa</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Jacob K. Long</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Porter</u>		14. NAME OF HUSBAND OR WIFE <u>Nantie 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>412-32-0215</u>	17. INFORMANT Address <u>Hubert Long, Gallatin, 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>Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>3 mi</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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 <u>Jan 5 - 59</u> and last saw her <u>17th Oct 59</u> alive on <u>17th Oct 59</u> Death occurred at <u>3:45 P.</u> <u>4:00</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>F. B. Bailey</u> (Degree or title)			22b. ADDRESS <u>201 Jamesport, Mo</u>		22c. DATE SIGNED <u>10/15/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10-17-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Brown Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Gallatin, Mo.</u>	
24. FUNERAL DIRECTOR <u>H. D. Johnson</u> ADDRESS <u>Hope Funeral Home, Gallatin, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>17 Oct. 1959</u>		26. REGISTRAR'S SIGNATURE <u>Hugh W. Engelbert</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 L. O. Dickerson

Licensed Embalmer No. 3302

B. O. Address Ballatin

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.