

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**=60-019235**

**FILED VS MAY 16 1960**

Registration District No. 141 Primary Registration District No. 5550 Registrar's No. 81

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Moeyes</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Moeyes</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Caulfield</u>		Length of stay in lb <u>8 yrs</u>	c. CITY OR TOWN <u>Caulfield</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>✓</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" 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) <u>Owen F. Long</u>	First <u>F</u> Middle <u>L</u> Last <u>O</u>	4. DATE OF DEATH <u>4/28-60</u>	Month <u>4</u> Day <u>28</u> Year <u>60</u>
--	--	------------------------------------	---

5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-11-73</u>	9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u>
-----------------	---------------------------	---	------------------------------------	-------------------------------------	--	--

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>✓</u>	11. BIRTHPLACE (City and state or country) <u>Waytenville, Ark</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
--	---	---	---

13a. FATHER'S NAME <u>Joseph Long</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah Mays</u>	14. NAME OF HUSBAND OR WIFE <u>✓</u>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u>	16. SOCIAL SECURITY NO. <u>✓</u>	17. INFORMANT <u>Kenon Long, Caulfield Mo</u>	Address <u>✓</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>congestive heart failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>arteriosclerotic heart disease</u> <u>2 years</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)	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 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 <u>        </u> Month, Day, Year <u>        </u> a.m. <u>        </u> p.m. <u>        </u>
---

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 March 1960 to 4/28/60 and last saw him alive on 4/27/60  
Death occurred at 6:15 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>M.H. Fowler M.D.</u>	22b. ADDRESS <u>West Plains</u>	22c. DATE SIGNED <u>5/4/60</u>
---	------------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REINTERMENT (Specify)	23b. DATE <u>4-30-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fowler</u>	23d. LOCATION (City, town, or county) (State) <u>Caulfield Mo</u>
---	-----------------------------	---	--

24. FUNERAL DIRECTOR <u>Robertson Matt Lane Mo</u>	25. DATE RECD. BY LOCAL REG. <u>5-9-60</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*H. S. Robertson*

Licensed Embalmer No. 343

P. O. Address West Hill

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