

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-019937

FILED VS. JUN 1 1960 170

Primary Registration District No.

Registrar's No.

89

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Laclede</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Conway</u>		Length of stay in lb <u>5 years</u>		c. CITY OR TOWN <u>Conway</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>Home in Conway</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>NONE</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>J.</u> Last <u>Long</u>				4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1960</u>					
5. SEX <u>Male</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>May 27 1873</u>		9. AGE (last birthday) <u>86</u> IF UNDER 1 YEAR: Months <u>11</u> Days <u>16</u> Hours <u></u> Min. <u></u> IF UNDER 24 HR: Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (City and state or country) <u>Laclede County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>James Long</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Bohannon</u>			14. NAME OF HUSBAND OR WIFE <u>Deceased</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>Clara Hudson Conway, Mo.</u> Address				
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>BRONCHOPNEUMONIA</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>CEREBRO VASCULAR ACCIDENT</u>							<u>14 days</u>		
DUE TO (c) <u>HYPERTENSIVE ARTERIOSCLEROTIC VASCULAR DIS.</u>							<u>20 yrs.</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 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 _____ 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>4-30-60</u> to <u>5-13-60</u> and last saw ^{her} him alive on <u>4-30-60</u> Death occurred at <u>5 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Robert J. Baris, M.D.</u>				22b. ADDRESS <u>Rt 2 Box 63 Marshfield, Mo.</u>			22c. DATE SIGNED <u>5-15-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>5/16/60</u>		23c. NAME OF CEMETERY OR CREMATOR <u>Steele Memorial</u>		23d. LOCATION (City, town, or county) <u>Hartsville</u>		(State) <u>Mo.</u>	
24. FUNERAL DIRECTOR <u>John Robinson Hartsville, Mo.</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>5-23-1960</u>		26. REGISTRAR'S SIGNATURE <u>Hella L. Hlay</u>				

(Licensed Embalmer's Statement on Reverse Side)

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 Walter C. Simpson

Licensed Embalmer No. 5071

P. O. Address Hartsville, Md

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.