

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-020809

STATE FILE NUMBER

Registration District No. 098 Primary Registration District No. _____ Registrar's No. 83

AMENDED

FILED JUL 6 1961

1. PLACE OF DEATH a. COUNTY <u>Daviess</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Daviess</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural Union Township</u>		c. CITY OR TOWN <u>Rural Union Twp.</u>	
Length of stay in 1b <u>8 Months</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>1/2 Mi. South Gallatin</u>		d. STREET ADDRESS (If outside, give location) <u>1/2 Mi. South Gallatin</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marinda Mae Long</u>			4. DATE OF DEATH Month Day Year <u>June 26 1961</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>4-6-1878</u>
9. AGE (last birthday) <u>83</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR 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>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Milan, Missouri</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Nathan Henthorn</u>	
13b. MOTHER'S MAIDEN NAME <u>Sallie Pono</u>		14. NAME OF HUSBAND OR WIFE <u>Harry E. Long (Dec'd)</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 Address <u>Mrs. Fred McKinney, 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>Circulatory collapse</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hour</u>
DUE TO (b) <u>Pulmonary metastasis of carcinoma, site undetermined.</u>			<u>unknown</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 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>June 23, 1961</u> to <u>June 26, 1961</u> and last saw her alive on <u>June 26, 1961</u>		Death occurred at <u>5:30 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>[Signature] M. D.</u>		22b. ADDRESS <u>Gallatin, Missouri</u>	22c. DATE SIGNED <u>6/28/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6-28-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Wood Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Milan, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Hope Funeral Home, Gallatin, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>7-1-1961</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

1961 JUL 7

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. Richardson

Licensed Embalmer No. 3302

P. O. Address Fall River

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.