

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-042652

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 11066

STATE FILE NUMBER

AMENDED

FILED DEC 1 1961

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5092 Milentz Ave. Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY _____ c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 5092 Milentz Ave. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
|---|--|--|--|

| | | | |
|---|-------------------|---|----------------|
| 3. NAME OF DECEASED (Type or print) NONA E. LONG | First Middle Last | 4. DATE OF DEATH Month Day Year Nov. 27 1961 | Month Day Year |
|---|-------------------|---|----------------|

| | | | | | | |
|--------------------------------|---|---|---|--|--------------------------------|------------------------|
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 4-25-1872 | 9. AGE (last birthday) 89 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Min. |
|--------------------------------|---|---|---|--|--------------------------------|------------------------|

| | | | |
|--|--|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | 10b. KIND OF BUSINESS OR INDUSTRY At Home | 11. BIRTHPLACE (City and state or country) Belle Plain, Ill. | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
|--|--|---|---|

| | | |
|--|--|--|
| 13a. FATHER'S NAME Thomas Adams | 13b. MOTHER'S MAIDEN NAME Mary Barton | 14. NAME OF HUSBAND OR WIFE Late Samuel C. Long |
|--|--|--|

| | | |
|--|---|---|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Address Mary L. Nourse 5092 Milentz Ave. |
|--|---|---|

| | |
|--|----------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INFIRMITIES of old age DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 794X | INTERVAL BETWEEN ONSET AND DEATH |
|--|----------------------------------|

| | |
|---|---|
| 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 checked="" 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 May 1954 **to** Nov 26-1961 **and last saw her** alive on Nov 26 1961
Death occurred at 7:55 P. **on** _____ **m on the date stated above, and to the best of my knowledge, from the causes stated.**

| | | |
|--|--|--|
| 22a. SIGNATURE (Degree or title) <u>J. H. Blackford M.D.</u> | 22b. ADDRESS <u>3903 Olive</u> | 22c. DATE SIGNED <u>11/28/61</u> |
|--|--|--|

| | | | |
|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal (Rail) | 23b. DATE Nov. 28, 1961 | 23c. NAME OF CEMETERY OR CREMATORY _____ | 23d. LOCATION (City, town, or county) (State) Bakersfield, Cal. |
|---|--|---|--|

| | | |
|---|---|---|
| 24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway Blvd. | 25. DATE RECD. BY LOCAL REG. NOV 28 1961 | 26. REGISTRAR'S SIGNATURE <u>Roan Smith. M.D.</u> |
|---|---|---|

DO NOT WRITE IN THESE SPACES

DOCUMENT

MEDICAL CERTIFICATION

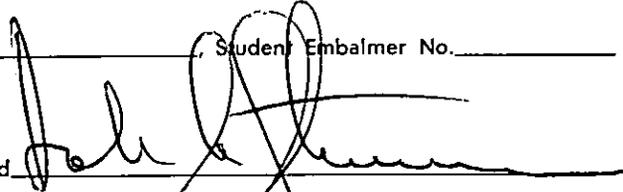
BY AFFIDAVIT OF

FORM 1 - 011 013 114

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  _____

Licensed Embalmer No. 4533

P. O. Address _____

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.