

Registration District No. **71**

Primary Registration District No. **4335**

Registrar's No. **63**

1. PLACE OF DEATH: **2**
(a) County **Monteale**
(b) City or town **California**
(c) Name of hospital or institution
(If outside city or town limits, write "RURAL" and name of township)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)

2. USUAL RESIDENCE OF DECEASED: **5**
(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

In this community _____
years, months or days
8. (a) PRINT FULL NAME **John Woods Longan**
3. (b) If veteran name war _____ 8. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **H** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Mrs. _____** 6. (c) Age of husband or wife If alive _____ years
7. Birth date of deceased **Jan 5 1860**
(Month) (Day) (Year)

8. AGE: Years **79** Months **10** Days **9** If less than one day _____ hr. _____ /min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____
12. Name **William L. Longan**
13. Birthplace **Monteale Co Mo**
(City, town, or county) (State or foreign country)
14. Maiden name **John**
15. Birthplace **Monteale Co Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **W. L. Longan**
(b) Address **California Mo**

17. (a) **Buried** (b) Date thereof **11/15/39**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Salmon Center**

18. (a) Signature of funeral director **William L. Longan**
(b) Address **California Mo**

19. (a) **11-15-39** (b) **W. H. Popejoy**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **14**
year **1939** hour **3** minute **2** A.M.
21. I hereby certify that I attended the deceased from **Sept 1**
1939, to **Nov 14**, 19**39**,
that I last saw him alive on **Nov 13**, 19**39**,
and that death occurred on the date and hour stated above.

Immediate cause of death **Arterio-sclerosis**
Due to **Cause unknown**
Due to _____

Duration **about 5 yrs.**

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) _____
(a) Means of injury _____

23. Signature **L. L. Nathan** (M. D. or other) _____
Address **California Mo** Date signed _____

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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 _____

_____, Registered Apprentice No. _____
working under my personal supervision.

Signed H E Frohman

Licensed Embalmer No. 21854

P. O. Address California M.

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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

40290

Do not use this space.

1. PLACE OF DEATH

(a) County Monteau Registration District No. 571
 (b) Township California Primary Registration District No. 4335
 (c) City California (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. da.

Registered No. _____

2. PRINT FULL NAME

(a) Residence, No. John Woods Longan St.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m
 (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS 79 MONTHS 10 DAYS 9 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Monteau (STATE OR COUNTRY) Mo.

FATHER
 13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
 15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 11-15- 1939 H. B. Popejoy (Registrar)

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 14, 1939

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____ (Signed) L. L. Latham, M. D.

(Address) California Mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

