WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

MAY 23 1931

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

13999

1. PLACE OF DEATH
County Iron
Registration District No. 390
File No. 8
Township Union
Primary Registration District No. 3540
Registered No. 8
City ..... (No. ..... St. ..... Ward)

2. FULL NAME Gertrude Long
(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Roscoe Long

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 7 1896

7. AGE 34 Years 5 Months 17 Days. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Madison Co
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER James Reed
11. BIRTHPLACE OF FATHER (CITY OR TOWN) St Francois
(STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Sarah Jane Young
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) [illegible]

14. INFORMANT Gertrude Copeland
(Address) Annapolis Mo

15. FILED 5-1-1931 B O Gunter REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 24 1931

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Saw the lady about 6 weeks before she died, [illegible] when she died they had no doctor. Think she had Post partum hemorrhage. There was no [illegible] they lived long ways from doctor
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) and she died before any Doctor got there
(duration) ..... yrs. ..... mos. ..... ds.

146 147

18. WHERE WAS DISEASE CONTRACTED, IF NOT AT PLACE OF DEATH? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) [illegible], M. D.
5-1-1931 (Address) [illegible] Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Des Arc Mo
DATE OF BURIAL Apr 25 1931

20. UNDERTAKER Neighbors acting
ADDRESS Annapolis Mo