

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUN 6 1947

Registration District No. 297

Primary Registration District No. 3057

Registrar's No. 58

1. PLACE OF DEATH:

(a) County Ray

(b) City or town Richmond
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
325 South Whitmer St.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ray

(c) City or town Richmond
(If outside city or town limits, write "RURAL")

(d) Street No. 325 South Whitmer St.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Linnie Eugene Neal

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife W.A. Neal

6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased Aug. 4 1876
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25 year 1947 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from May 23 - 1947 to May 25 1947
that I last saw her alive on May 25 - 1947
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Cerebral Hemorrhage
arterio Sclerosis

Duration _____

8. AGE: Years Months Days If less than one day

70 9 21 _____ hr. _____ min.

Due to _____

Due to _____

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

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

10. Usual occupation House Wife

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name Hohn C. West

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

14. Maiden name Anna Walker

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

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? No.

While at work? _____ (Specify type of place) _____

(e) Means of injury _____

23. Signature E. B. [unclear] (M. D. or other) _____
Address Richmond Mo. Date signed 5-28-47

16. (a) Informant John A. Bennett

(b) Address Richmond Mo.

17. (a) Burial (b) Date thereof May 28 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunny Slope, Richmond Mo.

18. (a) Signature of funeral director _____
(b) Address Richmond Mo.

19. (a) May 29 - 1947 (b) Malcolm Jackson
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

6-5-47

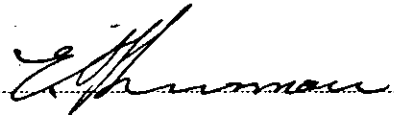
STATEMENT BY LICENSED EMBALMER

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.....



Licensed Embalmer No. 2073

P. O. Address. Richmond, Mo.

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, fact should be so stated above.