B 2 1 1929

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

Do not use this space.

1071

1. PLACE OF DEATH

County GREENE — Registration District No. 317 — File No.

Township REPUBLIC — Primary Registration District No. 5436 — Registered No.

City ..... (No. ..... St. ..... Ward)

2. FULL NAME RILLA O, NEAL

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

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: FEMALE
4. COLOR OR RACE: WHITE
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): MARRIED

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) APRIL 9 1879

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
49	8	28	

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

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) MISSOURI

PARENTS

10. NAME OF FATHER J.T.BRITAIN

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) MISSOURI

12. MAIDEN NAME OF MOTHER LUCY.MARBPLE

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) MISSOURI

14. INFORMANT Frank O. Neal
(Address) Republic Mo

15. FILED 1/8, 1929 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 7 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to Jan, 19..., that I last saw her alive on Jan 6, 1929, and that death occurred, on the date stated above, at 1 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza

11B 11B

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (SECONDARY) Nothing

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? at her Home
DID AN OPERATION PRECEDE DEATH? no DATE OF —
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Physical Signs
(Signed) E L Bell, M. D
, 19 (Address) Republic 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: Wades Chapel — DATE OF BURIAL: 1/8 1929

20. UNDERTAKER: R E Thurmon — ADDRESS: Republic Mo

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.

WHITE PERMANENT, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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