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.
1076

1. PLACE OF DEATH

County: Greene — Registration District No.: 317 — File No.:
Township: Pond Creek — Primary Registration District No.: 5438 — Registered No.:
City: (No. , St. Ward)

2. FULL NAME Zephi Frances Neil,

(a) Residence. No. R 1, Republic, Mo., 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*): Single

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: X X X X X X

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dec:16th:1878

7. AGE: Years 50 | Months - - - | Days 23 | If LESS than 1 day, ___ hrs. or ___ min.

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

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY): Missouri

PARENTS
10. NAME OF FATHER: W.W.Neil
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY): Missouri
12. MAIDEN NAME OF MOTHER: Martha Anna Keatts
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY): Missouri

14. INFORMANT: James Keatts
(Address): Billings, Mo.

15. Jan:9th: 29
FILED, 19 H.G.Frame
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan:8th:29 19

17. I HEREBY CERTIFY, That I attended deceased from 1-8th- 1929, to Jan:8th:29, 19, that I last saw her alive on Jan:8th:29, 19, and that death occurred, on the date stated above, at 11.20 P- m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Labar Pneumonia
IIA
168
(duration) yrs. mos. 5 ds.

CONTRIBUTORY (SECONDARY): Influenza
(duration) yrs. mos. 6 ds.

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) H.G.Frame, M. D
1-9-, 19 29 (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: Garroutte Cemetery
DATE OF BURIAL: 1-9th 19 29

20. UNDERTAKER: A. L. Wallace
ADDRESS: Billings, 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.

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