JUN 15 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 19094

Registration District No. 609 Primary Registration District No. 4343 Registrar's No. 71

1. PLACE OF DEATH:
(a) County: Newton
(b) City or town: Neosho
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Reynolds Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 24 Hours (Specify whether In this community years, months or days)

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

3. (a) PRINT FULL NAME: Bonnie Sue Wells 1420
3. (b) If veteran, name war:
3. (c) Social Security No.: none
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Infant
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: March (Month) 23 (Day) 1939 (Year)

8. AGE: Years 1 Months 1 Days 25 If less than one day ..... hr. ..... min.

9. Birthplace: Neosho (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Infant
11. Industry or business:
FATHER 12. Name: Clyde Wells
13. Birthplace: Olive (City, town, or county) Oklahoma (State or foreign country)
MOTHER 14. Maiden name: Pauline Hague
15. Birthplace: Pawnee Co. (City, town, or county) Oklahoma (State or foreign country)
16. (a) Informant's own signature: Clyde Wells
(b) Address: Neosho Mo. R#5
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5-19-40 (Month) (Day) (Year)
(c) Place: burial or cremation: Kenney Cemetery
18. (a) Signature of funeral director: Darley Thompson
(b) Address: Neosho Mo.
19. (a) 6-8-40 (Date received local registrar) (b) Anna R. Sale (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18 year 1940 hour 3 minute A. M.
21. I hereby certify that I attended the deceased from May 12, 1940, to May 18, 1940 that I last saw h. alive on May 18, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchopneumonia — Duration
Due to: —
Due to: —
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations: none
Of autopsy: none

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)
While at work? (e) Means of injury:
23. Signature: J. R. Reynolds (M. D. or other) MD
Address: Neosho Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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

I X19511

RECEIVED
District Health Officer No. 6
District File Number 640-1425
Date Filed JUN 12 1940

1072

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 Gail R. Gay, Registered Apprentice No. 189 working under my personal supervision.

Signed Carley Thompson
Licensed Embalmer No. 3259
P. O. Address Neosho 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, above space should be left blank.

No. 2B
2-21-40
I X22659

MOORE

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 19094

Registration District No. 609 Primary Registration District No. 4363 Registrar's No. 71

1. PLACE OF DEATH

(a) County Newton

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

(c) Name of hospital or institution:

(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

2. USUAL RESIDENCE OF DECEASED:

(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.

3. (a) PRINT FULL NAME Bonnie Swewell

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 1 Months 1 Days 25 If less than one day hrs. min.

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

10. Usual occupation

11. Industry or business

FATHER 12. Name

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

MOTHER 14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Bronchio Pneumonia

Due to There were no complications as

Due to Measles Whooping Cough etc

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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)

While at work? (e) Means of injury

23. Signature J. R. Reynolds (M. D. or other)

Address Neosho Date signed

SUPPLEMENTARY

S-19094