FILED SEP 16 1940

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28275

Registration District No. 198 Primary Registration District No. 3011 Registrar's No. 131

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

1. PLACE OF DEATH:

(a) County: Clay

(b) City or town: Excelsior Springs Mo. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 425 E. Broadway (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: 21 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Clay

(c) City or town: Excelsior Springs Mo (If outside city or town limits, write "RURAL")

(d) Street No.: 425 E. Broadway (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Nellie Fay Neal 400

3. (b) If veteran, name war: ____ 3. (c) Social Security No.: ____

4. Sex: Female 5. Color or race: W 6. (a) Single, widowed, married, divorced: Single

6. (b) Name of husband or wife: ____ 6. (c) Age of husband or wife if alive: ____ years

7. Birth date of deceased: Jan (Month) 11 (Day) 1895 (Year)

8. AGE: Years 45 Months 7 Days 9 If less than one day ____ hr. ____ min.

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

10. Usual occupation: maid work

11. Industry or business: McCleary Sanitarium

FATHER 12. Name: John Neal

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

MOTHER 14. Maiden name: Mary Allen

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

16. (a) Informant: Sterling Porter

(b) Address: Excelsior Springs Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug. 22, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation: Richmond Mo

18. (a) Signature of funeral director: Claude Gaithard

(b) Address: Excelsior Springs Mo.

19. (a) 8/22/40 (Date received by local registrar) (b) Mrs Rea McCracken (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 20th year 1940 hour 7 minute 45 P.M.

21. I hereby certify that I attended the deceased from Jan. 20, 1940 to Aug. 20, 1940 that I last saw her alive on Aug. 20, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchial Pneumonia — Duration: 4 days

Due to: ____

Due to: ____

Other conditions: menopause (Include pregnancy within 3 months of death)

Major findings: Of operations: — Of autopsy: no

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): no

(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: H. J. Clark (M. D. or other) 1

Address: Excelsior Springs Mo. Date signed: 8-22-40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 9-2-40

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 Walter Barker, Registered Apprentice No. 228 working under my personal supervision.

Signed Claude Richard

Licensed Embalmer No. 2757

P. O. Address Excelsior Springs

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.