

No. 2
4-13-40
-17-39
I X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

REC'D JAN 21 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **43348**

Registration District No. **619**

Primary Registration District No. **5821**

Registrar's No. _____

1. PLACE OF DEATH
 (a) County **Nodaway**
Clearmont, Rural Atchison Twp.
 (b) City or town
 (c) Name of hospital or institution
6 miles east Clearmont
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **58 years**
 (Specify whether years, months or days) **2**

3. (a) PRINT FULL NAME **James Wm. Neal**
 3. (b) If veteran, name war _____
 3. (c) Social Security No. **none**

4. Sex **M** 5. Color or race **W**
 6. (a) Single, widowed, married, divorced **widowed**
 6. (b) Name of husband or wife **Rebecca**
 6. (c) Age of husband or wife if alive **Dec. 27, 1856** years
 7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years **84** Months _____ Days **3** If less than one day hr. _____ min.

9. Birthplace **Green County, Ind**
 (City, town, or county) (State or foreign country)
 10. Usual occupation **Farmer**

11. Industry or business _____
 12. Name **James Neal**
 13. Birthplace **Kentucky**
 14. Maiden name **Hester McKenzie**
 15. Birthplace **Kentucky**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Gaylord Reynolds**
 (b) Address **Clearmont, Mo.**
 17. (a) **burial** (b) Date thereof **Jan. 1, 1941**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Oak Hill Cemetery**

18. (a) Signature of funeral director **Pricc Funeral Home**
 (b) Address **Marionville Mo**
 19. (a) **12/30-40** (b) **W.B. Humphrey**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Nodaway**
 (c) City or town **Clearmont, Rural Atchison Twp.**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **6 miles East Clearmont**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **Dec. 30, 1940** day _____
 year **1940** hour **8:15 AM** minute _____

21. I hereby certify that I attended the deceased from **12/1/40** to **12/30/40**, 19**40**
 that I last saw h. **live** on **12/29/40**, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death **Congestive heart failure**
 Due to **infection**
 Duration **24 hrs + 4 days**

Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
 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) **A**
 (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 **W.B. Humphrey** (M. D. or other) **MD**
 Address **Hopkins** Date signed **12/31/40**

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

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.....

Clum M Price

Licensed Embalmer No.....

1822

P. O. Address.....

Mayville

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.