DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32440

FILLED OCT 10 1941

Registration District No. 472 Primary Registration District No. 4463 Registrar's No. 1061

X26390

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

1. PLACE OF DEATH:
(a) County St Francois
(b) City or town Elvins Mo
(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
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County St Francois
(c) City or town Elvins 094
(If outside city or town limits, write "RURAL")
(d) Street No. 3
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Linnie Angeline Neagles

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 Married
6. (b) Name of husband or wife Chas Neagles
6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased May (Month) 10th (Day) 1875 (Year)

8. AGE: Years 66 Months 3 Days 14 If less than one day hr. min.

9. Birthplace (City, town, or county) Ky (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name Wm Willmuth
13. Birthplace (City, town, or county) Ky (State or foreign country)
MOTHER
14. Maiden name Mary E. Green
15. Birthplace (City, town, or county) Ky (State or foreign country)
16. (a) Informant Chas Neagles
(b) Address Elvins, Mo
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation Lost Cemetery Bismarck Mo
18. (a) Signature of funeral director Caldwell Bros
(b) Address Flat River Mo
19. (a) 8/25/41 (Date received local registrar) (b) C B Farrar MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 24 day August year 1941 hour minute M.

21. I hereby certify that I attended the deceased from 8/22, 1941 to 8-24, 1941; that I last saw her alive on 8-24, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pneumonia	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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 F. W. Gale (M. D. or other)
Address Bismarck Mo Date signed 8/25/41

69 (Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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

If this body is not embalmed, fact should be so stated above.

No. 2B
-8-21-41
I X29288

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. 32 440

Registration District No. 772 Primary Registration District No. 4463 Registrar's No.

1. PLACE OF DEATH:
(a) County St Francois
(b) City or town (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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Linnie A. Neagles
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex H
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased May 10 1875 (Month) (Day) (Year)

8. AGE: Years 66 Months 3 Days If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) Burial (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 day year hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pneumonia	
Due to Lobar	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 108	
Of autopsy	

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 F. H. Gale (M. D. ~~or other~~)
Address Bismarck Mo Date signed

SUPPLEMENTARY