

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24507**

FILED AUG 27 1944

Primary Registration District No. **4154**

Registrar's No. **43**

1. PLACE OF DEATH:

(a) County **Madison**
(b) City or town **Greenfield**
(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) **1**
(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 **Madison**
(c) City or town **Greenfield**
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Neely, N. Bush**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **non**

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **W. H. Bush** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Feb 22 1872**
(Month) (Day) (Year)

8. AGE: Years **72** Months **5** Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation **house wife**

11. Industry or business _____

12. Name **Benjamin Miller**
13. Birthplace **Ohio** (City, town, or county) (State or foreign country)
14. Maiden name **Lois Miller**
15. Birthplace **unknown** (City, town, or county) (State or foreign country)

16. (a) Informant **W. H. Bush**
(b) Address **Greenfield MO**
17. (a) **Burial** (b) Date thereof **7 25 44**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **collins cemetery**

18. (a) Signature of funeral director **W. B. Allen**
(b) Address **Greenfield MO**
19. (a) **7-25-44** (b) **Phyllis Lact**
(Date received local registry) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **7** day **22** year **44** hour **6 P.M.** minute _____ M.
21. I hereby certify that I attended the deceased from **7-10-44** to **7-22-44**
that I last saw him alive on **7-10** and that death occurred on the date and hour stated above.

Immediate cause of death **apoplexy**
Due to _____
Due to _____

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? _____
While at work? _____ (Specify type of place) (2) Means of injury _____

23. Signature **H. O. Cowan** (M. D. or other) _____
Address **Greenfield MO** Date signed **7-24-44**

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

29-0

1082

RECEIVED

District Health Officer No. 61
District File Number 844-888
Date Filed 8-4-44

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.....

Wm R. Allison

Registered Apprentice No. *366*

working under my personal supervision.

Signed *R. L. Hamschick*

Licensed Embalmer No. *3234*

P. O. Address *Laurewood Hill*

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.