

FILED NOV 14 1944
Registration District No. 326

Primary Registration District No. 4482

Registrar's No. 48

1. PLACE OF DEATH:

(a) County Scotland
(b) City or town Memphis
(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 Entire Life years, months or days

3. (a) PRINT FULL NAME

John William Neese
3. (b) If veteran name war. 3. (c) Social Security No. _____4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced married6. (b) Name of husband or wife Emma 6. (c) Age of husband or wife if alive 90 years7. Birth date of deceased Oct 8 1854
(Month) (Day) (Year)8. AGE: Years 90 Months 10 Days _____ If less than one day hr. _____ min. _____9. Birthplace Stanton Va
(City, town or county) (State or foreign country)10. Usual occupation Retired Farmer

11. Industry or business

12. Name Jacob Neese
13. Birthplace Va
(City, town or county) (State or foreign country)
14. Maiden name Mary F. Owen
15. Birthplace Va
(City, town or county) (State or foreign country)16. (a) Informant Mrs. H. J. Grosztemper
(b) Address Baring Mo17. (a) Burial (b) Date thereof Oct 17-44
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Greenbury Mo
Bethel(a) Signature of funeral director Bernice Wilson
(b) Address Memphis Mo(a) Oct. 26, 1944 (b) Bernice Wilson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scotland
(c) City or town Memphis 99
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 18
year 1944 hour 12 minute 15 A. M.21. I hereby certify that I attended the deceased from Oct. 3
1944, to Oct. 12, 1944;
that I last saw him alive on Oct 12, 1944,
and that death occurred on the date and hour stated above.Immediate cause of death Nephritis Duration 5 yrs.

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:

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) _____ (e) Means of injury _____

23. Signature E. E. Symmonds (M. D. or other) MDAddress Memphis Mo Date signed Oct 26 1944

RECEIVED

District Health Officer No. 10

District File Number 11-44-1889

Date Filed NOV 10 1944

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 Fred Gerst

Licensed Embalmer No. 4256

P. O. Address Memphis

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 326

Primary Registration District No. 4482

Registrar's No. 48

1. PLACE OF DEATH

(a) County Scotland

(b) City or town Memphis
(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)

3. (a) PRINT FULL NAME John W. Reese

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M

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 Oct 8
(Month) (Day) (Year)

8. AGE: Years 90 Months _____ Days _____ (if less than one day) min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct Day 18 Year 1944 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____
that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to Acute Nephritis ✓

Due to Following Influenza ✓

Other conditions (include pregnancy within 3 months of death) _____

Major findings: _____

Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) (c) Means of injury _____

23. Signature E. E. Symonds (M.D. or other) _____

Address Memphis Date signed Mo.

SUPPLEMENTARY

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

35436