

No. 2
-5-42
-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41492**

FILED JAN 8 1945

Registration District No. **71845**

Primary Registration District No. **4285**

Registrar's No. **104**

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

1. PLACE OF DEATH:

(a) County **Lewis**

(b) City or town **Lewistown**
(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 **Missouri** (b) County **Lewis** **56**

(c) City or town **Lewistown.**
(If outside city or town limits, write "RURAL") **67**

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ **7**

3. (a) PRINT FULL NAME **Louise Ellen McNeil**

(b) If veteran, name war **no**

(c) Social Security No. **no**

4. Sex **Female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Widowed**

(b) Name of husband or wife **Thomas Cecil McNeil**

(c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Dec. 13, 1862**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

81. **11** **10** hr. min.

9. Birthplace **Falls Mills·Vig.**
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business _____

MOTHER FATHER

12. Name **Jacob Buckland**

13. Birthplace **Vig.**
(City, town, or county) (State or foreign country)

14. Maiden name **Martha Compton**

15. Birthplace **Vig.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Olns Larson**

(b) Address **Lewistown, Missouri**

17. (a) **Burial** (b) Date thereof **Nov. 26, 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oakwood Cemt. Miles Mo**

18. (a) Signature of funeral director **Jewald**

(b) Address **Lewistown, Missouri**

19. (a) **11/28/44** (b) **P. W. Jennings, M.D.**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **23**
year **1944** hour **1** minute **15** M.

21. I hereby certify that I attended the deceased from **Oct. 15**
44 to **Nov 23** 19 **44**
that I last saw her _____ alive on **Nov 23** 19 **44**
and that death occurred on the date and hour stated above.

Immediate cause of death **acute myocarditis**

Due to **Pneumonia (Streptococcal)**

Due to _____

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

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? _____

23. Signature **John W. Jones** (M. D. or other) **P.D.**
Address **Lewistown, Mo** Date signed **12-24-44**

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 10.

District File Number 1-45-38

Date Filed JAN 5 1945

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 Myself
....., Registered Apprentice No.
working under my personal supervision.

Signed.....

Licensed Embalmer No. 2532

P. O. Address Lewistown Mo

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. Jan
Registrar's No. 109

Registration District No. 178

Primary Registration District No. 4280

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

1. PLACE OF DEATH:
 (a) County Lewis
 (b) City or town Lewistown
(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)

3. (a) PRINT FULL NAME Louise E. McNeil
 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 W
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec 13 1906
(Month) (Day) (Year)

8. AGE: Years 81 Months _____ Day _____
If less than one day hr. _____ min.

9. Birthplace _____
(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 Mar day 23
 year 1942 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ 19____
 that I last saw him/her alive on _____ 19____
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Duration _____
Lobar Pneumonia

Due to _____
 Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy _____

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? _____

23. Signature Chas. H. Mowery, M.D. (M. D. or other) _____
 Address Lewistown, Mo. Date signed _____
While at work? _____ (Specify type of place) Means of injury _____

SUPPLEMENTARY INFORMATION REQUESTED

41492