

FILED APR 2 1946
Registration District No. 22

Primary Registration District No. 207

Registrar's No.

1. PLACE OF DEATH:
(a) County COOPER
(b) City or town BOONVILLE
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
ST. JOSEPH'S HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 DAYS (Specify whether
In this community 20 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County COOPER
(c) City or town BOONVILLE
(If outside city or town limits, write "RURAL")
(d) Street No. 616 LeRoy (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME RAYMOND P. CREAL
(b) If veteran, name war NONE
(c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month MARCH day 8
year 1946 hour 2 minute _____ P.M.

4. Sex MALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
(b) Name of husband or wife ALTA CREAL
(c) Age of husband or wife if alive _____ years
7. Birth date of deceased FEBRUARY 7 1893
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Feb 26 1946 to Mar 8 1946
that I last saw him alive on Mar 8 1946
and that death occurred on the date and hour stated above.

8. AGE: Years 53 Months 1 Days 1
If less than one day _____ hr. _____ min.

Immediate cause of death Coronary occlusion Duration 10 days

9. Birthplace CREAL SPRINGS ILLINOIS
(City, town, or county) (State or foreign country)

Due to Coronary disease

10. Usual occupation CONDUCTOR

Due to _____

11. Industry or business M.K. & T. RAILROAD

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

12. Name AMANDA BROWN

Major findings: Of operations none *PH*

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

Of autopsy Coronary occlusion

14. Maiden name E.R. CREAL

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

15. Birthplace CREAL SPRINGS ILLINOIS
(City, town, or county) (State or foreign country)

16. (a) Informant MRS R.P. CREAL

(b) Address BOONVILLE, MO.

17. (a) BURIAL (b) Date thereof 3/11/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation WALNUT GROVE CEM.

18. (a) Signature of funeral director STEGNER

(b) Address BOONVILLE, MO.

19. (a) 3-12-1946 (b) Clay Morris
(Date received local registrar) (Registrar's signature)

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) (e) Means of injury _____

23. Signature J.C. Beckett MD (M.D. or other)

Address Boonville mo Date signed 3.11.46

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

MOTHER FATHER

INDEX NO.

H-1-46

APR 5 1946

MAR 3 1947

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..... *James W Stegner*
Licensed Embalmer No. *37800*
P. O. Address..... *Boonville, 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.

Registration District No. 82

Primary Registration District No. 3017

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Cooper
 (b) City or town Boonville
(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 Raymond P. Neal
 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 _____
 7. Birth date of deceased Feb 7
(Month) (Day) (Year)

8. AGE: Years 53 Months _____ 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) _____ (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) 3/21/46 (b) Colin Moore
(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 Jan year 1946 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ to _____, 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 _____
 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?
(Specify type of place)
 While at work? _____ (e) Means of injury _____
 23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

8897

MAR 3 1947