DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Haley 5373

State File No.

FILED MAR 10 1947

Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 6

1. PLACE OF DEATH:

(a) County: Linn

(b) City or town: Brookfield (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 609 N. Main St. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community 65 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Linn 58

(c) City or town: Brookfield (If outside city or town limits, write "RURAL") 1

(d) Street No.: 609 N. Main (If rural, give location) 2

(e) Citizen of foreign country? No (Yes or No) 8

If yes, name country

3. (a) PRINT FULL NAME: JOHN BEVERLY NEECE

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: M 0

5. Color or race: W.

6. (a) Single, widowed, married, divorced: M 1

6. (b) Name of husband or wife: Ann Neece

6. (c) Age of husband or wife if alive: 78 years

7. Birth date of deceased: May (Month) - 24 (Day) - 1859 (Year)

8. AGE: Years 87 Months 8 Days 28 If less than one day hr. min.

9. Birthplace: Linn Co (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation: Retired Salesman

11. Industry or business:

FATHER 12. Name: George W. Neece

13. Birthplace: D.K. (City, town, or county) Ill 1 (State or foreign country)

MOTHER 14. Maiden name: D.K.

15. Birthplace: D.K. (City, town, or county) D.K. 9 (State or foreign country)

16. (a) Informant: Guy Neece

(b) Address: Brookfield Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb-24-1947 (Month) (Day) (Year)

(c) Place: burial or cremation: Rose Hill Cemetery

18. (a) Signature of funeral director: Hill Funeral Home

(b) Address: Brookfield Mo.

19. (a) 2-25-47 (Date received local registrar) (b) Walter Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 22 year 1947 hour 9 minute a M.

21. I hereby certify that I attended the deceased from Mar 13, 1939, to Feb 22, 1947, that I last saw him alive on Feb 22, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Generalized Arteriosclerosis	1 yr
Due to: Senility	—
Due to:	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy: 97	

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) 0

While at work? (e) Means of injury

23. Signature: R. Oy R. Haley (M. D. or other) M.D.

Address: Brookfield Mo. Date signed 2-25-47

(Licensed Embalmer's Statement on Reverse Side)

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

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 J. R. Blackstock

Licensed Embalmer No. 2246

P. O. Address Brookfield Mo

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

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

2B
45
43880

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

DEPARTMENT OF COMMERCE
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STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 6

1. PLACE OF DEATH:

(a) County: Linn

(b) City or town: Brookfield (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: John B. Neece

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: May (Month) 24 (Day) 1860 (Year)

8. AGE: Years 87 Months 8 Days 28 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business: Retired Salesman

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, 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 February 22 year 1947 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

S-5373