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ev. 5-17-39
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Super

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12164

FILED APR 8 1947

Registration District No. 381

Primary Registration District No. 4515

Registrar's No.

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

1. PLACE OF DEATH:
 (a) County Sullivan
 (b) City or town Milan
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Simpson Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 18 days
(Specify whether years, months or days)
 In this community 21 year's

3. (a) PRINT FULL NAME Dolly McNealey
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex FM / 5. Color or race W
 6. (a) Single, widowed, married, divorced widowed
 6. (b) Name of husband or wife Dean A. McNealey 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased 4 / 28 / 1925
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>21</u>	<u>10</u>	<u>10</u>	hr. _____ min.

9. Birthplace Cova / 1110 U
(City, town, or county), (State or foreign country)

10. Usual occupation House Wife

11. Industry or business _____

MOTHER FATHER
 12. Name Chas L Morris
 13. Birthplace Cova / 1110 U
(City, town, or county) (State or foreign country)
 14. Maiden name Elva Lawrence
 15. Birthplace Milan / 1110 U
(City, town, or county) (State or foreign country)

16. (a) Informant Irene Walker
 (b) Address Milan 1114

17. (a) Burial (b) Date thereof 3-10-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oakwood Cem

18. (a) Signature of funeral director Schaenz
 (b) Address Milan Mo

19. (a) April 1-1947 (b) Mrs. H. B. Harris
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Sullivan¹⁰⁵
 (c) City or town Milan / 1
(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 3 day 8
 year 1947 hour 7 minute 10 P.M.
 21. I hereby certify that I attended the deceased from Feb. 14, 1947, to March 8, 1947.
 that I last saw her alive on March 8, 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death
intestinal perforation with pelvic abscess.
 Due to Selpingitis
 Due to undetermined origin.
 Other conditions _____
(Include pregnancy within 3 months of death)

Duration
<u>12 hrs.</u>
<u>2 mo.</u>

Major findings:
 Of operations abdominal surgery
Feb. 20 - 1947
 Of autopsy abdominal pathology

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 Simpson (M. D. or other) 100
 Address Milan Date signed 3-9-47

320 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
DISTRICT HEALTH DEPARTMENT, No. 10
DISTRICT HEALTH DEPARTMENT
APR - 5 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..... *Dwight Schaefer*

Licensed Embalmer No. *2667*

P. O. Address..... *Melba 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