

Health, Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED AUG 22 1956

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 296664

Registration District No. 366 Primary Registration District No. 6241 Registrar's No. 56

1. PLACE OF DEATH a. COUNTY <i>Washington</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> COUNTY <i>Washington</i>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Rural Bretton Twp</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <i>Rural 1100</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Near Petasi</i>			Length of stay in lb <i>1 year</i>		d. STREET ADDRESS (If outside, give location) <i>Near Petasi</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <i>Frank</i> Middle <i>Neel</i> Last <i>Neel</i>				4. DATE OF DEATH Month <i>Aug</i> Day <i>14</i> Year <i>1956</i>					
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct. 2 1873</i>		9. AGE (In years last birthday) <i>82</i>		10. UNDER 1 YEAR IF UNDER 24 HRS. Months <i>10</i> Days <i>12</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hammer work</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (City and state or country) <i>Franklin Co. Mo</i>		12. CITIZEN OF WHAT COUNTRY? <i>—</i>		
13. FATHER'S NAME <i>Mason Neel</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Mary Garbrough Mineral Point Mo</i>				Address <i>RR 1</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hemorrhage colon</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>carcinoma colon</i> DUE TO (c) <i>—</i>								INTERVAL BETWEEN ONSET AND DEATH <i>153X</i>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>						
20c. TIME OF INJURY Hour <i>—</i> Month <i>—</i> Day <i>—</i> Year <i>—</i> a. m. <i>—</i> p. m. <i>—</i>			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. CITY, TOWN, OR LOCATION <i>—</i>		COUNTY <i>—</i>		STATE <i>—</i>			
21. I attended the deceased from <i>Aug 10</i> to <i>Aug 14/56</i> and last saw <i>him</i> alive on <i>Aug 14</i> Death occurred at <i>11 am</i> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Doctor or Coroner) <i>E. S. Russell</i>				22b. ADDRESS <i>Petasi Mo</i>		22c. DATE SIGNED <i>8/17/56</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>8-15-56</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Metcalf Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Washington Co. Mo.</i>				
24. FUNERAL DIRECTOR <i>Mrs. Lillian Sparks Petasi Mo</i>			ADDRESS <i>—</i>		25. DATE RECD BY LOCAL REG. <i>8/18/56</i>		26. REGISTRAR'S SIGNATURE <i>Robert Ruback</i>		

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

AUG 21

WASH. COUNTY HEALTH DEPT.

File No. _____

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 _____, Student Embalmer No. _____ working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Mary L. Sparks*
Licensed Embalmer No. *139*
P. O. Address *1215 1/2*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.