N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Stone

Township Pierce
or
Village
or
City ~~C~~ (NO. St.; Ward)

Registration District No. 842 File No. 12735-a

Primary Registration District No. 604 Registered No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME S. P. Neill

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE white

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widower

6 DATE OF BIRTH April (Month) 24 (Day) 1842 (Year)

7 AGE 76 yrs. 10 mos. 13 ds. If LESS than 1 day, ...hrs. or ....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry business, or establishment in which employed (or employer) —

9 BIRTHPLACE (City or town, State or foreign country) Tenn.

PARENTS

10 NAME OF FATHER Hiram Neill

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Tenn.

12 MAIDEN NAME OF MOTHER Runyon

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Tenn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. W. Rea
(Address) Crane Mo.

15 Filed 5-2 1919 R W Kelly Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar. 7 (Month) (Day) 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from March 4, 1919, to March 4, 1919, that I last saw him alive on March 4, 1919, and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

apoplexy

64 (Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) —

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. L. Tate M. D.

3-18-, 1919 (Address) Crane Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Crane Cemetery

DATE OF BURIAL Mar. 8, 1919

20 UNDERTAKER W. E. Hilton

ADDRESS Crane

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ..... (Day), 1..... (Year)

7 AGE

.....yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or .....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day), 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....

that I last saw h.....alive on ....., 191.....,

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) .....yrs.....mos.....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) .....yrs.....mos.....ds.

(Signed) .....M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191.....
20 UNDERTAKER	**ADDRESS**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.