LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

17079

V. S. No. 2.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

LACE OF DEATH
County Scotland — Registration District No. 810 — File No.
Township — Primary Registration District No. 4488 — Registered No. 24
City Memphis (No. ..... St. ..... Ward)

ULL NAME Francis Angeline Mc neely
(a) Residence. No. Memphis, Mo. St., ... Ward. (If nonresident give city or town and State)
(Usual place of abode)
of residence in city or town where death occurred 7 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
le	white	widowed

MARRIED, WIDOWED, OR DIVORCED
USBAND OF
OR) WIFE OF Zed Mcneely

TE OF BIRTH (MONTH, DAY AND YEAR) June 23rd 1848

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
76	10	17	

CUPATION OF DECEASED
) Trade, profession, or rticular kind of work Housekeeper
) General nature of industry, siness, or establishment in hich employed (or employer)
) Name of employer

THPLACE (CITY OR TOWN) Scotland Co. Mo.
STATE OR COUNTRY)

NAME OF FATHER Don't Know

BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Illinois

MAIDEN NAME OF MOTHER Don't know

BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Don't Know

FORMANT Mrs Etta McNeely
ddress) Gorin, Mo

LED 5/12, 1925 E E Parrish
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 10 1925

17. I HEREBY CERTIFY, That I attended deceased from April ~~May~~ 10, 1925, to May 10, 1925 that I last saw her alive on May 10, 1925, and that death occurred, on the date stated above, at 11 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (SECONDARY) Chronic Interstitial Nephritis associated with arteriosclerosis (duration) 10 yrs. ~~10~~ mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) A M Keeth, M. D
May 11, 1925 (Address) Memphis Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Union Cemetery — DATE OF BURIAL: May 11 1925

20. UNDERTAKER: Smith & Barkett — ADDRESS: Gorin, Mo

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....

2. FULL NAME .....

(a) Residence. No..... St., ...Ward.. .....
(Usual place of abode) (If nonresident give city or town and State

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

17.
I HEREBY CERTIFY, That I attended deceased from .....
.....,19....., to .....
that I last saw h..... alive on....., 19.....,
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(duration).....yrs. .....mos.

CONTRIBUTORY.....
(SECONDARY)
.....(duration).....yrs. .....mos.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed).....
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSE (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICI HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BU
20. UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

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