

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

Do not use this space.

22007

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **791**
Primary Registration District No. **1003**

File No.....
Registered No. **6174**
St..... Ward.....

2. FULL NAME

(a) Residence. No. **1323 N. 13th** St. **25** Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. **9** mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF **Willie Neal**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Sept. 15, 1900**

7. AGE YEARS MONTHS DAYS H LESS than 1 day, hrs. or min.
27 **8** **20**

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Laborer**
(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) **Ala.**

10. NAME OF FATHER **Ike Neal**

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

12. MAIDEN NAME OF MOTHER **Ella Bullock**

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

14. INFORMANT (Address) **Anna F. Woodard City Hospital #25**

15. FILED **11-9-1928** REGISTRAR **May C. Standiford**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **6-5-1928**

17. I HEREBY CERTIFY, That I attended deceased from **5-22-1928**, to **6-5-1928** that I last saw him alive on **6-5-1928**, and that death occurred, on the date stated above, at **8:20 PM** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
31 23m
(duration) yrs. **5** mos. ds.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? **no** DATE OF.....

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **X ray and path**
(Signed) **T. B. Cunningham**, M. D.
, 19 (Address) **2945 Johnston**

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Centaw, Ala.

DATE OF BURIAL

6-9-1928

20. UNDERTAKER

Cum Bros

ADDRESS **215 E. Jefferson**

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.

