

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

Do not use this space.

2592

1. PLACE OF DEATH

County Monroe
Township Washington
City (No.) (St.) (Ward)

Registration District No. 582
Primary Registration District No. 5780

File No.
Registered No. 1

2. FULL NAME

Mary Neal
(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 50 yrs. mos. ds. How long in U.S., if of foreign birth? 84 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

female white widowed

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

Francis Neal

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

May 18, 1839

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, ... hrs. or ... min.
89	7	16	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at home
(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) Germany

10. NAME OF FATHER

N. S.

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) N. S.

12. MAIDEN NAME OF MOTHER

M. S.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) N. S.

14.

INFORMANT Carl Brinker
(Address) Paris, Mo.

15.

FILED 1/4 1929 H. C. Payne
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 4 1929.

17. I HEREBY CERTIFY That I attended deceased from Jan 4 1929 at Paris, Mo. that I last saw h. e. alive on Jan 4 1929, and that death occurred, on the date stated above, at 9:15 AM.

THE CAUSE OF DEATH WAS AS FOLLOWS:**

Chronic Gout Fladder
injection

12-7-23 (duration) 10 yrs. x mos. x ds.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH. NO DATE OF.....

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS Clinical signs

(Signed) H. C. Payne, M. D.

1/4 1929 (Address) Paris, 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Salem

DATE OF BURIAL

1/5 1929

20. UNDERTAKER

Speed & Blakey

ADDRESS

Paris, Mo.

N. B.—Every item of information should be carefully checked for accuracy. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

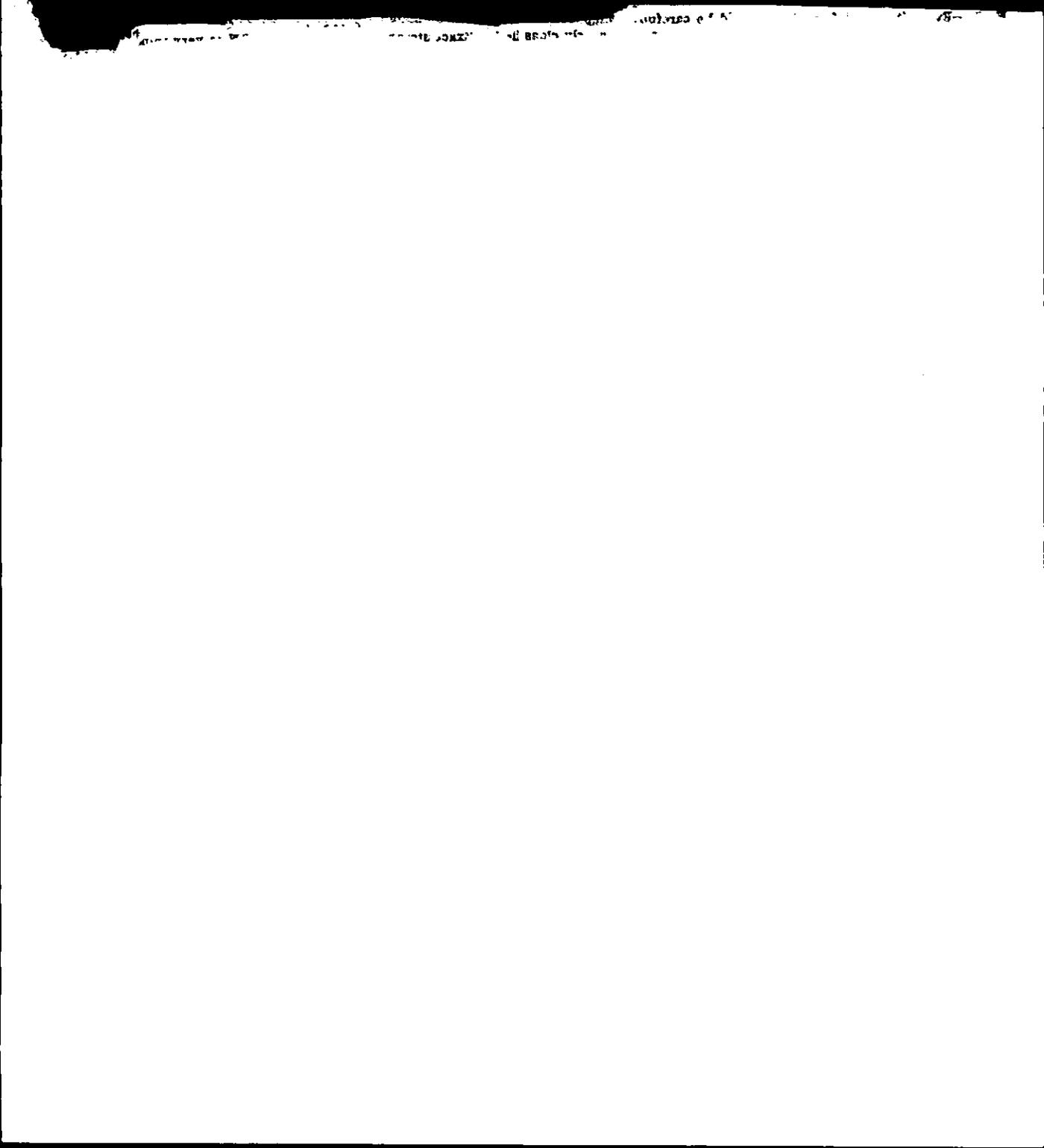
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**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Monroe Registration District No. 5-82 File No. _____
Township Washington Primary Registration District No. 5-780 Registered No. 1
City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Mary Seal

(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. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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) _____

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 1-4-29 HC Payne
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) JAN 4 1929

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, of _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Chronic Gull bladder infection, Charley
injection unknown
(duration) _____ yrs. _____ mos. _____ ds.

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

18. WHERE WAS DISEASE CONTAINED _____
IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.
, 19____ (Address) _____

*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 _____ DATE OF BURIAL _____

20. UNDERTAKER _____ ADDRESS _____

N. B.—Every item of information should be carefully checked. AGOR should be stated EXACTLY. PHYSICIAN'S PROFESSIONAL STATEMENT OF OCCUPATION IS VERY IMPORTANT. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

1240

S-2592