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

Do not use this space.

5398

RR 21 1929

1. PLACE OF DEATH

County: Barton — Registration District No.: 44 — File No.:

Township: Central — Primary Registration District No.: 5066 — Registered No.: 1

City: ..... (No. ....., ... St. ..... Ward)

2. FULL NAME: Jacob Neas

(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: Male

4. COLOR OR RACE: White

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 9-16-1845

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
83	4	25	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

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

(c) Name of employer: .....

1

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

2

PARENTS

10. NAME OF FATHER: Phillip Neas

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

2

12. MAIDEN NAME OF MOTHER: Elizabeth Bowes

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

2

14. INFORMANT: C. L. Neas.
(Address): Liberal, Mo.

15. FILED 2-14 1929 G. E. Locker M. D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

1

16. DATE OF DEATH (MONTH, DAY AND YEAR): Feb 11 1929

17. I HEREBY CERTIFY, That I attended deceased from Feby 10, 1929, to Feby 11, 1929, that I last saw him alive on Feby 10, 1929, and that death occurred, on the date stated above, at 6:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Haemorrhage

82A

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

CONTRIBUTORY (SECONDARY) .....

(duration) ..... yrs. ..... 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) Thos F Miller, M. D

, 19 (Address) Lamar, 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: Lake Cemetery

DATE OF BURIAL: Feb 12 1929

20. UNDERTAKER: C. F. Konantz

ADDRESS: Lamar, Mo

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.