

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

Do not use this space.

7394

18

1. PLACE OF DEATH
 County Newton Registration District No. 609
 Township..... Primary Registration District No. 4363
 City Neosho (No.) St. Ward.....

2. FULL NAME James Leroy Clingenpeel
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 12, 1929

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
24

8. OCCUPATION OF DECEASED

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

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

PARENTS

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
 (STATE OR COUNTRY) Not known

12. MAIDEN NAME OF MOTHER Opal Clingenpeel

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

14. INFORMANT Chas. Clingenpeel
 (Address) Neosho Mo

15. FILED 3/10 1929 B. E. Mawers
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-5 1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Unknown
eyes now closed at birth
No physician in charge
 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) 20510
 (duration) yrs. mos. da.

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) J. Reynolds, M. D.
2/5/29 (Address) Neosho 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 Gibson Cemetery DATE OF BURIAL 2/5 1929

20. UNDERTAKER Biglan's ADDRESS Neosho

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.

MAR 25 1929

Reynolds

