

JUN 5 1930

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

Do not use this space.

15915

1. PLACE OF DEATH

County *Henry*
Township *Zussville*
City (No.) (No.) St. Ward)

Registration District No. *347*
Primary Registration District No. *5501A*

File No.
Registered No. *34*

2. FULL NAME

Eldon W. McNeely

(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

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 18 1930*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Albert W. McNeely*

17. I HEREBY CERTIFY, That I attended deceased from *May 10 1930* to *May 18 1930* that I last saw him alive on *May 17 1930* and that death occurred, on the date stated above, at. m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *2-11-1930*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *3 7*

15B) Erysipelas

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

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

9. BIRTHPLACE (CITY OR TOWN) *Henry Co Missouri* (STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH

10. NAME OF FATHER *Albert W. McNeely*

0 DID AN OPERATION PRECEDE DEATH? *no* DATE OF ... WAS THERE AN AUTOPSY? *no*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Henry Co Missouri* (STATE OR COUNTRY)

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) *Samuel J. Progan, M.D.*

12. MAIDEN NAME OF MOTHER *May Shuck*

(Address) *Blount MO, 5/18 1930*

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

*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.

14. INFORMANT *C. C. Repordine* (Address) *Co. Rd. 1*

19. PLACE OF BURIAL, CREMATION, OR REMOVAL, DATE OF BURIAL *Taber Cemetery 5/19 1930*

15. FILED *5/19 1930* *Dr. E. C. Peeler* REGISTRAR

20. UNDERTAKER *James Walker & Co* ADDRESS

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.

State of Alaska
Department of Fish and Game

Alaska
Department of Fish and Game

1961

1962

**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 Henry Registration District No. 347 File No. a
 Township Fresville Primary Registration District No. 5-5-01 Registered No. 34
 City Eldon (No.) St. Ward)

2. FULL NAME Eldon McFeely
 (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

MEDICAL CERTIFICATE OF DEATH

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

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 18 1930

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

THE CAUSE OF DEATH WAS AS FOLLOWS:
Erysipelas
Do not know the cause
 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY)

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)

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 216

DID AN OPERATION PRECEDE DEATH? DATE OF

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.

15. FILED 5/19 30 D. H. E. C. Peeler REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-15915