

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

Do not use this space.
7229

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City, **St. Louis** (No. **Deaconess Hospital**) St. _____ Ward)

File No. _____
Registered No. **1538**

2. FULL NAME

(a) Residence. No. **Carl Wesley Neely** St., **4th** Ward, **Makesville**
(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) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 14 1929		
7. AGE	YEARS	MONTHS
	1	5
		DAYS
		20
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... None (b) General nature of industry, business, or establishment in which employed (or employer)..... (c) Name of employer.....		

9. BIRTHPLACE (CITY OR TOWN) **Mo** (STATE OR COUNTRY) **1**

PARENTS	10. NAME OF FATHER Wesley Neely
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo (STATE OR COUNTRY) 1
	12. MAIDEN NAME OF MOTHER Lillie Swanson
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo (STATE OR COUNTRY) 1

14. INFORMANT **Wesley Neely** (Address) **Makesville Mo**

15. FILED **1931** REGISTRAR **W. C. Stewart**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Feb. 4 1931**

17. I HEREBY CERTIFY, That I attended deceased from **Feb 2** 1931, to **Feb 4** 1931, that I last saw him alive on **Feb 4** 1931, and that death occurred, on the date stated above, at **11:35 P. m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
tuberc pneumonia

(duration) yrs. mos. ds. **5**

CONTRIBUTORY (SECONDARY) **Nothing** (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
108
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? **No** DATE OF _____
WAS THERE AN AUTOPSY? **No**
WHAT TEST CONFIRMED DIAGNOSIS? **Phys sig**
(Signed) **John H. Sutter**, M. D.
2/6 1931 (Address) **6500 Maple, 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 Zions Cemetery	DATE OF BURIAL Feb. 7 1931
20. UNDERTAKER Drehmann Paul	ADDRESS 1905 Union

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.

RECORD

~~6509 B. ...~~

6500 Mafell

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