

Dr. Rozell

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

Do not use this space.

38231

1. PLACE OF DEATH

County Mason
Township Mason
City Hannibal (No. 1911)

Registration District No. 547
Primary Registration District No. 3029
Gordon

File No.
Registered No. 286
St. 6 Ward

2. FULL NAME

James Thornton Mc Neal
(a) Residence, No. 1911 Gordon St. 6 Ward.

(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
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 21-1847
7. AGE YEARS 84 MONTHS 4 DAYS 14 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Hannibal Lumber Wheel Foundry
10. Date deceased last worked at this occupation (month and year) 1915 11. Total time (years) spent in this occupation 14 yrs

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ralls Co Mo

13. NAME David Mc Neal

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Scotland

15. MAIDEN NAME Sophina Willis

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jonesville Ohio

17. INFORMANT Melvin S. Mc Neal (ADDRESS) Hannibal Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Baskley Cemetery DATE Nov. 7-1931

19. UNDERTAKER Schwartz Funeral Home (ADDRESS) Hannibal Mo

20. FILED Nov 7 1931 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 7-1931

22. I HEREBY CERTIFY, That I attended deceased from Oct 13-1931 to Nov 3-1931

I last saw him alive on Nov 5-1931 Death is said to have occurred on the date stated above, at 9:20 P.M.

The principal cause of death and related causes of importance were as follows:

Paralysis Date of onset Oct 13-31

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify Dr. Rozell (Signed)....., M. D.

(Address) Hannibal Mo

WRITE PLAINLY, WITH UN-
NECESSARY INFORMATION SHOULD BE CAREFULLY SUPPLIED. EXACTLY. PHYSICIANS SHOULD STATE 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 Marion Registration District No. 547 File No. 286
 Township _____ Primary Registration District No. 3029 Registered No. _____
 City Hannibal (No. _____) St. _____ Ward _____

2. FULL NAME

James Thornton McNeal
 (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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

FATHER 13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19.

19. UNDERTAKER (ADDRESS) _____

20. FILED 9-7 1931 C E Cousins Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 5 - 1931

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____. I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m. The principal cause of death and related causes of importance were as follows:

Paralysis following Arterial Sclerosis
 Date of onset _____
 Other contributory causes of importance: _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____ (Signed) D A Roselly, M. D.
 (Address) _____

SUPPLEMENTARY

FADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully checked and stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. A correct statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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