

DEC'D FEB 16 1939

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

Do not use this space.

1. PLACE OF DEATH

County *New Madrid*Registration District No. *55*File No. *10*Township *Anderson*Primary Registration District No. *6262*Registered No. *1357*City *256* (No. *256*)

St. _____ Ward _____

2. FULL NAME

(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 *Single*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *1-17-39*

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

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) *New Madrid* (STATE OR COUNTRY) *Mo.*13. NAME *Walter McNeil*14. BIRTHPLACE (CITY OR TOWN) *New Madrid* (STATE OR COUNTRY) *Mo.*15. MAIDEN NAME *Eva M. Bendig*16. BIRTHPLACE (CITY OR TOWN) *New Madrid* (STATE OR COUNTRY) *Mo.*17. INFORMANT *W. McNeil* (ADDRESS) *New Madrid Mo.*

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19

19. UNDERTAKER *None* (ADDRESS) *541*20. FILED *Feb 12 1939* *M. V. Munnica* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *?* 19 *39*22. I HEREBY CERTIFY, That I attended deceased *at death* _____, 19 *39*I last saw him *alive* _____, 19 *39* Death is said

to have occurred on the date stated above, at _____

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

Unknown. Mother had small pox months ago and infant has been dead some time - at least a week. one of twins

Other contributory causes of importance:

the other twin alive

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) *J. B. Starnes*, M. D.(Address) *Clarkton Mo.*

