

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

30402
Do not use this space.

REC'D SEP 14 1939

1. PLACE OF DEATH *2*

(a) County Stone Registration District No. 842

(b) Township Pierce Primary Registration District No. 6104 Registered No. _____

(c) City _____ (d) Street No. _____ St. _____

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME James R. Neill

(a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 20-1862

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

76 11 2

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. farmer

9. Industry or business in which work was done, as 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) Stone MS

FATHER 13. NAME Sam Neill

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Stone MS

MOTHER 15. MAIDEN NAME Mrs. Nancy Wilton

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

17. INFORMANT (ADDRESS) Mrs. J. W. Brown

18. BURIAL, CREMATION, OR REMOVAL PLACE Crane DATE Sept 4 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Gene A. Marlane

20. FILED Sept 4 1939 Mrs. Ethel Doyt Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 2, 19 39

22. I HEREBY CERTIFY, That, I attended deceased from June 16, 1939, to Sept 2, 1939

Last saw him alive on Sept 2, 1939. Death is said to have occurred on the date stated above, at 7:15 p.m.

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

Coronary Occlusion
Hypertensive Heart disease

Other contributory causes of importance: HTV
Left hemiplegia

Date of onset 9-2-39

Name of operation None Date of _____

What test confirmed diagnosis? Clinical Was there an autopsy? No

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. P. Joplin, M. D.

(Address) Crane, Mo.

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.

RECEIVED

District Health Officer No. 6,

District File 939-1854

Date Filed SEP 8 1939

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed George H. Manslowe

Licensed Embalmer No. 3877

P. O. Address Crane Yds

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.