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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

JUN 13 1940 316

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 18402

Registrar's No. 419

Registration District No. _____

Primary Registration District No. 2001

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County GREENE
 (b) City or town SPRINGFIELD
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Springfield Baptist Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days)

8. (a) PRINT FULL NAME Leola Iona Oneal 154D
 8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced W
 6. (b) Name of husband or wife Norwood Oneal 6. (c) Age of husband or wife if alive 27 years
 7. Birth date of deceased June 1 1911
 (Month) (Day) (Year)

8. AGE: Years ✓ 28 Months 11 Days 5 If less than one day _____ hr. _____ min.

9. Birthplace Golden City Mo
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____
 12. Name Corda Adlow
 13. Birthplace Unknown (City, town, or county) (State or foreign country)
 14. Maiden name Essie Patterson
 15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Norwood O'neal
 (b) Address Republic Mo R. 1

17. (a) _____ (b) Date thereof May 8 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Golden City, Mo

18. (a) Signature of funeral director R. E. Thurman
 (b) Address Republic Mo

19. (a) 5-8-40 (b) M. E. Haudley MD
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town Republic
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 6
 year 1940 hour 13 minute 30 P.M.
 21. I hereby certify that I attended the deceased from Apr 20
1940 to May 6 1940
 that I last saw her alive on May 6 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Asphyxia
Collapse of trachea

Due to Post operative hemorrhage
following thyroidectomy 5/6/40
 Due to _____

Other conditions (Include pregnancy within 3 months of death) bleb

Major findings: Acute thyroiditis in
nontoxic diffuse goiter
 Of autopsy _____

Duration sudden
 PHYSICIAN _____
 Underline (the cause to which death should be charged statistically).

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
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While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature Robert Glynn (M. D. or other) MD
 Address Springfield Date signed 5/6/40

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

X