

Registration District No. **605**

Primary Registration District No. **4359**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **New Madrid**
(b) City or town **Pisco Rural**
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community **3 wks 1** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **New Madrid**
(c) City or town **Pisco Rural**
(d) Street No. _____
(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME **Joe Edward Neal**

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex **male** 5. Color or race **white**
6. (b) Name of husband or wife _____ 8. (a) Single, widowed, married, divorced **single**
7. Birth date of deceased **Aug 22 1934**
(Month) (Day) (Year)

8. AGE: Years **6** Months **6** Days **20** If less than one day hr. _____ min.

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

10. Usual occupation **School boy**

11. Industry or business _____

MOTHER FATHER { 12. Name **Robert Neal**
13. Birthplace **June 1**
14. Maiden name **Nancy Sidwell**
15. Birthplace **June 1**

16. (a) Informant **Robert Neal**

(b) Address **Wilbourn Mo. R.H. 1**

17. (a) **Burial** (b) Date thereof **3-13-41**
(Burial, cremation, or removal) (Specify) (Day) (Year)

(c) Place: burial or cremation **Caruthersville Mo**

18. (a) Signature of funeral director **W. L. Smith**
(b) Address **Caruthersville Mo**

19. (a) **3-12-41** (b) **Dr. G. G. G. G.**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **3** day **12**
year **41** hour **2** minute **45 P.M.**

21. I hereby certify that I attended the deceased from **Mar 10 1941** to **Mar 12 1941**
that I last saw him alive on **Mar 10 1941**
and that death occurred on the date and hour stated above.

Immediate cause of death **Polar Pneumonia**

Due to **Following measles**

Due to _____

Other conditions **35**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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?
534 While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **Dr. G. G. G. G.** (M. D. or other) _____
Address **Parma Mo** Date signed **3/12/41**

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

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

2000

RECEIVED

District Health Officer No. 2

District File Number 441-4-8

Date Filed 4/11/44

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. _____

R. 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.