

FILED OCT 10 1941

Registration District No. 25

Primary Registration District No. 100

Registrar's No. 928

1. PLACE OF DEATH:

(a) County: Buchanan  
(b) City or town: Saint Joseph  
(c) Name of hospital or institution: Mercy Hospital  
(d) Length of stay: In hospital or institution: 8 hrs  
In this community: 8 yrs

3. (a) PRINT FULL NAME: Herbert Oreal

3. (b) If veteran:  name war:   
3. (c) Social Security No.: unknown

4. Sex: M  
5. Color or race: W  
6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Donnelly Oreal  
(c) Age of husband or wife if alive: 18 years

7. Birth date of deceased: 27 1931 (Month) (Day) (Year)

8. AGE: Years 19, Months 11, Days 26, If less than one day:  hr.  min.

9. Birthplace: Genery MO (City, town, or county) MO (State or foreign country)

10. Usual occupation: Restaurant attendant

11. Industry or business: 11

12. Name: Charley Oreal

13. Birthplace: Genery MO (City, town, or county) MO (State or foreign country)

14. Maiden name: Wynette Evans

15. Birthplace: Genery MO (City, town, or county) MO (State or foreign country)

16. (a) Informant: Charley Oreal

(b) Address: Saint Joseph MO

17. (a) Burial, cremation, or removal:  (b) Date thereof: 9-23-41 (Month) (Day) (Year)

(c) Place: burial or cremation: Saint Joseph MO

18. (a) Signature of funeral director: Jaton H. Phillips

(b) Address: Saint Joseph MO

19. (a) Date received local registrar: 9/23/41 (b) Registrar's signature: Jaton H. Phillips

2. USUAL RESIDENCE OF DECEASED:

(a) State: MO (b) County: Genery  
(c) City or town: Saint Joseph MO  
(d) Street No.: 158  
(e) Citizen of foreign country?  (Yes or No)  
If yes, name country: 20

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Sept, day: 23, year: 1941, hour: 5, minute: 16, M.

21. I hereby certify that I attended the deceased from P M 9/22 1941, to 5 2 AM 9/23 1941, (that I last saw him alive on 9/23 and that death occurred on the date and hour stated above.

Immediate cause of death: Crushed Head and Chest. Duration: \_\_\_\_\_

Due to: auto accident, truck and auto collision  
Due to: \_\_\_\_\_

Other conditions: 1700 (Include pregnancy within 3 months of death)

Major findings:  Of operations:

Of autopsy:  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): accident

(b) Date of occurrence: 9/23/41, about 5:16 P M

(c) Where did injury occur: 1700 (City or town) MO (County) MO (State)

(d) Did injury occur in or about home, on farm, in industrial place, or public place? Public Road

While at work?  (Specify type of place) (e) Means of injury: auto accident

23. Signature: H. S. Conrad (M. D. or other)

Address: Saint Joseph MO Date signed: 9/23/41

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

1941-20-83  
1921-9 27  
1911 26

**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 Ratoy F. Phillips

Licensed Embalmer No. 1898

P. O. Address. Stoughton, M.

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

**If this body is not embalmed, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 31087  
Registrar's No. 926

Registration District No. 85 Primary Registration District No. 1001

1. PLACE OF DEATH:

(a) County St. Buchanan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Meth Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community 2 1/2 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Gentry  
(c) City or town Kingston City MO  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Charles Herbert O Neal

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept. 27 1921  
(Month) (Day) (Year)

8. AGE: Years 19 Months 11 Days \_\_\_\_\_ (If less than one day) \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry of business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Nov. 3-41 (b) A.J. Nestlebusch  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day 28 year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature A. J. Nestlebusch (M. D. or other) M. D.

Address St. Joseph Date signed 11/3/41

SUPPLEMENTARY

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1941  
S-31087