

Registration District No.

Primary Registration District No.

Registrar's No.

FILED OCT 16 1941

609

4363

97

1. PLACE OF DEATH:

- (a) County NEWTON
- (b) City or town NEOSHO
(If outside city or town limits, write "RURAL" and name of township)
- (c) Name of hospital or institution:
McDONALD Hospital
(If not in hospital or institution, write street number or location)
- (d) Length of stay: In hospital or institution one week
(Specify whether years, months or days) 0 (Specify whether years, months or days)

3. (a) PRINT FULL NAME

WILLIAM INNES3. (b) If veteran,
name war.NONE3. (c) Social Security
No. NONE

4. Sex MALE 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife IDA INNES 6. (c) Age of husband or wife if alive 21 years
7. Birth date of deceased OCTOBER 21 1867
(Month) (Day) (Year)

8. AGE: Years 73 Months 10 Days 22 If less than one day
hr. min.9. Birthplace MARYVILLE TENN.
(City, town, or county) (State or foreign country)10. Usual occupation FARMER

11. Industry or business

12. Name JOHN INNES
13. Birthplace UNKNOWN SCOTLAND
(City, town, or county) (State or foreign country)
14. Maiden name MARGARET CULTON
15. Birthplace MARYVILLE TENN.
(City, town, or county) (State or foreign country)

16. (a) Informant Everett Jackson(b) Address Neosho, Missouri17. (a) Burial (b) Date thereof 9-13-1941
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation High Cemetery18. (a) Signature of funeral director Carlyle T. Johnson(b) Address Neosho, Mo.19. (a) 10-1-41 (b) Frank R. Salsbery
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Newton 073
- (c) City or town Painview 0
(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 _____ 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT. day 12
year 1941 hour 11:20 minute _____ a. m.21. I hereby certify that I attended the deceased from Sept 5, 1941, to Sept 12, 1941.
that I last saw him alive on Sept 12, 1941.
and that death occurred on the date and hour stated above.Immediate cause of death intestinal obstruction ✓
Duration 4 days

Due to _____

Due to _____

Other conditions
(Include pregnancy within 3 months of death)Major findings:
Of operations NoneOf autopsy None

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? _____

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

23. Signature C. E. Manresa (M. D. or other) M.D.Address Neosho, Mo. Date signed Oct 1-41

RECEIVED

District Health Officer No. 6,

District File Number 1441-1598

Date Filed OCT 13 1941

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 Carley Thompson

Licensed Embalmer No. 3259

P. O. Address Neosho Mo.

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32132

Registration District No. 609

Primary Registration District No. 4363

Registrar's No.

1. PLACE OF DEATH:

(a) County Newton

(b) City or town Neosho
(If outside city or town limits, write "RURAL" and name of township)

(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.....
(Specify whether years, months or days)

In this community.....
(Specify whether years, months or days)

3. (a) PRINT FULL NAME William Innes

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 w

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

7. Birth date of deceased Oct 21, 1867
(Month) (Day) (Year)

8. AGE: Years 73 Months 10 Days 14 (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.....
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) 10-1-41 (b) Wm. R. Sal... ..
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town.....
(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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day 12
year 1941 hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....
....., 19.....
that I last saw him..... alive on....., 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death intestinal obstruction
Duration.....

Due to This was malignant

Due to.....

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

Major findings:
Of operations.....
Of autopsy.....
PHYSICIAN Hol
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?
.....
(Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

32182