

Registration District No. **257**

Primary Registration District No. **9048**

Registrar's No. **157**

1. PLACE OF DEATH:

(a) County **Nodaway**
(b) City or town **Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Francis hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **18 months**
In this community **10 years** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Ella Virginia O'Neal**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **NO**

4. Sex **female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced, **widowed**

6. (b) Name of husband or wife **James O'Neal** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **December 21 1867**
(Month) (Day) (Year)

8. AGE: Years **75** Months **9** Days **16** If less than one day hr. _____ min.

9. Birthplace **Cairo Illinois** (City, town, or county) (State or foreign country)

10. Usual occupation **housewife**

11. Industry or business **Joseph E. Early**

12. Name **Unknown** Ill. **1**

13. Birthplace **Lucy Lay** (City, town, or county) (State or foreign country)

14. Maiden name **unknown** Ill. **1**

15. Birthplace **Walter Hale** (City, town, or county) (State or foreign country)

16. (a) Informant **McCammon Idaho**

(b) Address **burial 10-10-43**

17. (a) **I.C.C.F. Cemetery Quitman Mo.** (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director **Price Funeral Home**

(b) Address **Mayville mo**

19. (a) **Oct-12-43** (b) **Ann Barber**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Nodaway 074**
(c) City or town **Burlington Junction**
(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 **Oct.** day **7th** year **1943** hour **3** minute **P.** M.

21. I hereby certify that I attended the deceased from **April 15** 19**43** that I last saw her alive on **Oct 7** 19**43** and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary atherosclerosis**
Old myocarditis
Due to **old cardio vasculis**

Due to _____
Other conditions (include pregnancy within 3 months of death) **93d**

Major findings: Of operations _____
Of autopsy _____

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) (b) Means of injury _____

23. Signature **B. F. Ryland** (M. D. or other) **MD**
Address **Mayville Mo** Date signed **10-2-43**

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

2-43
7-39
X3569

FILED NOV 12 1943

1547

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.....

Wm L Gee

Licensed Embalmer No.

2539

P. O. Address.....

Manville 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 270V.

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County Hodaway
(b) City or town Maryville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Francis Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 18 mo. (Specify whether
In this community 10 yrs. (Specify whether
years, months or days)

3. (a) PRINT FULL NAME

ella V. O'Neal

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex 7

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 Dec. 21-1866
(Month) (Day) (Year)

8. AGE: Years 75 Months 9 Days 1 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) (Burial, cremation, or removal) _____ (b) Date thereof _____
(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Oct. 12-78 (b) Amy Barber
(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 Oct day _____
year 1943 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 _____

Duration

Due to _____

Due to _____

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

Major findings:

Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

35408