

No. 2  
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-17-39  
X35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED APR 4 1944**

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10837

State File No. \_\_\_\_\_

Registration District No. 97

Primary Registration District No. 6290

Registrar's No. 42

1. PLACE OF DEATH:

(a) County Dallas

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

(c) Name of hospital or institution South Benton  
(If not in hospital or institution, write street number or location) P

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community 24 yrs  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dallas<sup>30</sup>

(c) City or town Buffalo Rural<sup>30</sup>  
(If outside city or town limits, write "RURAL")

(d) Street No. S. Benton  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME DAVIDEL CLINTON NEIL

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 4  
year 1944 hour 7 minute 45 AM

21. I hereby certify that I attended the deceased from Dec 20 1943 to March 4 1944  
that I last saw him alive on March 4 1944  
and that death occurred on the date and hour stated above.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ella Neil

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased Aug 19 1874  
(Month) (Day) (Year)

Immediate cause of death Coronary Occlusion

Due to Arterio Sclerosis 12 yrs

Due to Renal disease 5 yr

Other conditions None

(Include pregnancy within 3 months of death)

8. AGE: Years 69 Months 6 Days 14  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Thomas Neil

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

14. Maiden name May Lunde

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

16. (a) Informant Bert Neil

(b) Address Buffalo Mo

17. (a) Burial (b) Date thereof Mar 6 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Lawn

18. (a) Signature of funeral director L B Jones

(b) Address Buffalo Mo

19. (a) Mar 29 1944 (b) Miss A. Hoover  
(Date received local registration) (Registrar's signature)

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 W. H. Hemmer (M. D. or other) MD

Address Buffalo Mo Date signed 3-13-44

Duration 36 Mo

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

1124

(Licensed Embalmer's Statement on Reverse Side)

Director of Health Under No. 7,  
Permit Number 3-44-316  
Date Issued 4-5-44

**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 Chas. A. Roof

Licensed Embalmer No. 3048

P. O. Address Buffalo, N.Y.

**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.**

Registration District No. 97 Primary Registration District No. 6290

1. PLACE OF DEATH:  
(a) County Dallas  
(b) City or town Rural South Benton  
(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 \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days  
3. (a) PRINT FULL NAME Daniel G. 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 Aug 19 1937  
(Month) (Day) (Year)

8. AGE: Years 69 Months 6 Days \_\_\_\_\_ If less than one day, \_\_\_\_\_ min.

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

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

11. Industry or 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) \_\_\_\_\_ (b) \_\_\_\_\_  
(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 March year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion Duration 30 min  
Due to arterio sclerosis 12 yrs  
Due to renal disease OK  
Chronic  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN  
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? \_\_\_\_\_

23. Signature L. H. Hemmer (M. D. or other) MD  
While at work \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
Address Buffalo Mo Date signed 4-9-44

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

SUPPLEMENTARY

10837