

Registration District No. 339

Primary Registration District No. 6149

State File No. _____
Registrar's No. 12

1. PLACE OF DEATH:
(a) County Stoddard
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Hick Creek Twp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Stoddard 103
(c) City or town Puxico, Rural
(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 Eliza Cordelia O'Neal,
3. (b) If veteran, name war _____ **3. (c) Social Security** No. _____

4. Sex F **5. Color or race** W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Jim **6. (c) Age of husband or wife if** Jim O'Neal **alive** _____ **years**
7. Birth date of deceased July 18 1877
(Month) (Day) (Year)

8. AGE: Years 66 Months 11 Days 26
If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____
12. Name John Williams
13. Birthplace Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Eliza Burk,
15. Birthplace Tenn.
(City, town, or county) (State or foreign country)

16. (a) Informant Jim O'Neal
(b) Address Puxico Missouri,

17. (a) Burial Burial **(b) Date thereof** 7 16 44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director Watkins Service
(b) Address Puxico Mo

19. (a) 7-24-1944 **(b) J. S. Williams**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 14
year 1944 hour 2 p.m. minute _____ M.
21. I hereby certify that I attended the deceased from 9-12
_____, 1944, to 7-14-44, 1944
that I last saw h. alive on 7-12-, 1944,
and that death occurred on the date and hour stated above.

Immediate cause of death _____ **Duration** _____
Cancer of Rectum + Pelvic Organ
Due to Cancer of Uterus
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 A. M. Wiley **(M.-D. or other)** OO.
Address Puxico Mo. **Date signed** 7-24-44

MOTHER FATHER

1132

RECEIVED

District Health Office No.

District File Number *844-16*

Date Filed *8-9-4*

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 *Raymond Steele*

Licensed Embalmer No. *2476*

P. O. Address *Wester 72*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Aug
Registrar's No. 129

Registration District No. 339 Primary Registration District No. 6149

1. PLACE OF DEATH:

(a) County Stoddard
(b) City or town Rural Duch Grech Twp
(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 _____)
In this community _____ (years, months or days)

3. (a) PRINT FULL NAME Elyia C Neal
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 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 _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 66 Months 11 Days 26 If less than one day _____ min.

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

10. Usual occupation Housewife

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) _____ (Date received local registrar) (b) J. K. Stearns (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 July Year 1944 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 _____

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