

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 16 1945

Registration District No. 195

Primary Registration District No. 4244

Registrar's No. 16

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Carterville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 301 North Tennessee
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 (Specify whether
In this community 56 years (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 4
(c) City or town Carterville 6
(If outside city or town limits, write "RURAL")
(d) Street No. 301 N. Tennessee
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country U.S.

3. (a) PRINT FULL NAME Tabitha Ellen Nealy

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

4. Sex Female 5. Color or race W. 6. (a) Single, widowed, married, Divorced Widowed

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

7. Birth date of deceased October 26 1851
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
93 1 16 hr. min.

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

10. Usual occupation housewife

11. Industry or business _____

12. Name Samuel B. Brockman

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

14. Maiden name Mary Francis Boatwright

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

16. (a) Informant Son: Horace Nealy

(b) Address Carterville, Mo.

17. (a) burial (b) Date thereof 12/14/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Carterville Cemetery

18. (a) Signature of funeral director Hedge-Lewis

(b) Address Webb City, Mo.

19. (a) Dec 14 1944 (b) Mrs. Lillian Lagle
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 12
year 1944 hour 11 minute 0 A. M.

21. I hereby certify that I attended the deceased from ? 1944 to Dec 12 1944
that I last saw her alive on Dec 12 1944
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Carcinoma of throat.
Due to 1. cancerous condition.

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? _____

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

23. Signature Dr. P. M. Pense (Print name) or other? P.O.

Address Carterville, Mo. Date signed 12-13-44

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

4
0

457

1180

44-12-1114

Permit

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..... *E. M. Hedge*

Licensed Embalmer No. *28519*

P. O. Address..... *Webb City*

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.