

U.S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

FRIED JUN 29 1945

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2576

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town St. Luke
(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 and location)

(d) Length of stay: In hospital or institution 7 Day 6 hours
(Specify whether _____)
(e) Citizen of foreign country? no (Yes or No)

In this community 7 Day 6 hours 50 minutes
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 13

(c) City or town Hamilton
(If outside city or town limits, write "RURAL")

Street No. _____ (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME INFANT NEALE

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 2

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

7. Birth date of deceased June 14 1945
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 15
year 45 hour 3 minute 15 P.M.

21. I hereby certify that I attended the deceased from 6/15/45 to 6/15/45, 1945
that I last saw him alive on 7:30 AM, 1945
and that death occurred on the date and hour stated above.

8. AGE: Years _____ Months 1 Days 6 hrs 50 min.
If less than one day

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

Immediate cause of death prematurity

Due to premature labor following operation for appendicitis

Due to _____

Other conditions (Include operations within 3 months of death) none - on mother

Major findings: _____

Of operation _____

Of autopsy 159

11. Industry or business _____

12. Name Heart Neale

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

14. Maiden name Sarah Webb

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

16. (a) Informant P. Earle Neale
(b) Address Hamilton Mo

17. (a) Reverend (Burial, cremation, or removal) (b) Date there June 16, 1945
(Month) (Day) (Year)

(c) Place: burial or cremation Hamilton Mo

18. (a) Signature of funeral director Bruce Jurek Home
(b) Address Hamilton Mo

19. (a) 6-16-45 (Date received local registrar) (b) Geraldine Helmer (Registrar's signature)

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) (c) Means of injury _____

23. Signature Don Miller M.D. (M. D. or other)
Address St. Luke Hospital Date signed 6/16/45

Wes 77.77

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.....

Licensed Embalmer No.....

P. O. Address.....

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.