S. No. 2
M—2-43
. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JUL 30 1945

State File No. 23113

Registration District No. 149 Primary Registration District No. 1602 Registrar's No. 3033

1. PLACE OF DEATH:

(a) County Jackson,

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

(c) Name of hospital or institution:
3210 Wayne /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution no. (Specify whether
In this community 12 months
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson, 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 3210 Wayne 8
(If rural, give location)

(e) Citizen of foreign country? no. (Yes or No) 0

If yes, name country x

3. (a) PRINT FULL NAME John Ford Neal

3. (b) If veteran, name war no.

3. (c) Social Security No. no.

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife Florence Neal

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

7. Birth date of deceased April (Month) 14 (Day) 1875 (Year)

8. AGE: Years 70 Months 3 Days 5 If less than one day ___ hr. ___ min.

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

10. Usual occupation at home

11. Industry or business x

FATHER
12. Name Thomas Neal
13. Birthplace unknown, 9 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Stuart
15. Birthplace unknown, 9 (City, town, or county) (State or foreign country)

16. (a) Informant H. Ralph Neal,
(b) Address 3210 Wayne, Kansas City, Mo.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 7-21-45 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Moriah

18. (a) Signature of funeral director Stine & McClure,
(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 7-20-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19
year 1945 hour 5:45 minute A. M.

21. I hereby certify that I attended the deceased from 6/15-44, 19__, to July 19, 1945
that I last saw him alive on 7/18/45, 19__;
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma Larynx Primary metastasis to lung

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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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 Walter Helbrook (M. D. or other)
Address 1132 Prof Bldg Date signed 7/20/45

(Licensed Embalmer's Statement on Reverse Side)

Dr. Walter Holbrook
Prof. Bldg
1 to 3

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. Plank

Licensed Embalmer No. 1848

P. O. Address K.C. 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.