

FILED NOV 28 1945

Registration District No. 217

Primary Registration District No. 5786

Registrar's No. 72

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

7
0
6

1. PLACE OF DEATH:
 (a) County Mississippi
 (b) City or town Charleston (rural) Chenoweth
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: R#2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community All Of Life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Norma Jean Neal
 3. (b) If veteran, name war: ---
 3. (c) Social Security No. ---

4. Sex F 5. Color or race Negro 6. (a) Single, widowed, married, divorced Infant
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased September 18th 1945
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>0</u>	<u>3</u>	_____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
 12. Name Dave Neal
 13. Birthplace Ammarilla Ark
 (City, town, or county) (State or foreign country)
 14. Maiden name Geraldine Jones
 15. Birthplace Weldon Ark
 (City, town, or county) (State or foreign country)

16. (a) Informant Dave Neal
 (b) Address Charleston, Mo. R#2
 17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-45
 (Month) (Day) (Year)
 (c) Place: burial or cremation Oak Grove, Charleston, Mo.

18. (a) Signature of funeral director John F. [Signature]
 (b) Address Charleston, Mo.
 19. (a) 10/12/45 (Date received local registrar)
 (b) Ms. John [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Miss, 67
 (c) City or town Charleston, (rural)
 (If outside city or town limits, write "RURAL")
 (d) Street No. R#2 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 21st
 year 1945 hour 4 minute A M.
 21. I hereby certify that I attended the deceased from birth 19____ to Sept 18 19____
 that I last saw her alive on Sept 18 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death Congenital Heart
 Due to _____
 Due to _____

Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: Of operations none
 Of autopsy none

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

23. Signature E. Charles [Signature] (M. D. or other)
 Address Charleston, Mo. Date signed 9/22/45

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

RECEIVED

District Health Office No. 2,

District File Number 1145-323

Date Filed 11-8-48

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.

not embalmed

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.