

No. 2
-2-43
-17-39
X35697

STANDARD CERTIFICATE OF DEATH

State File No. 40678
Registrar's No. 369

Registration District No. 23

Primary Registration District No. 5142

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

1. PLACE OF DEATH:

(a) County Butler

(b) City or town Neelyville, Mo. Star Rt.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: NEELY Twp
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Butler

(c) City or town Neelyville, Mo. Star Rt.
(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 Lloyd E. Conley

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 13 year 1945 hour 8 minute 10 P.M.

21. I hereby certify that I attended the deceased from 12/10 to 12/13 1945 and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced

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

7. Birth date of deceased June 30 1945
(Month) (Day) (Year)

Immediate cause of death: Acute Cardiac Disease 1 day

Due to Pneumonia 3 days

Other conditions (Include pregnancy within 3 months of death) _____

8. AGE: Years 0 Months 5 Days 13 If less than one day hr. _____ min. _____

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

10. Usual occupation _____

Major findings: Of operations _____ Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

MOTHER FATHER

11. Industry or business _____

12. Name James E. Conley

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

14. Maiden name Phoda Carter

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

16. (a) Informant Phoda Conley
(b) Address Neelyville, Mo. Star Rt.

17. (a) Burial (b) Date thereof 12-14-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Timney Cem.

18. (a) Signature of funeral director W. H. Deby
(b) Address Canaan, Mo.

19. (a) 12-22-45 (b) W. H. Deby
(Date received local registrar) (Registrar's signature)

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 W. H. Deby (M. D. or other) _____
Address Canaan, Mo. Date signed 12/14/45

RECEIVED

District Health Office No. 2,

District File Number 146-3422

Date Filed 1-2-46

Body was not embalmed

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 Walter Johnson

Licensed Embalmer No. 686 + 47

P. O. Address Canning, Pa.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 43

Primary Registration District No. 4742

Registrar's No. 369

1. PLACE OF DEATH:

(a) County Butler

(b) City or town Neelsville
(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 (Specify whether _____)

3. (a) PRINT FULL NAME Lloyd E. Bonley

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s

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

7. Birth date of deceased June 30 1944
(Month) (Day) (Year)

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

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

10. Usual occupation _____

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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (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 10 Day 3 year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to Lobar pneumonia's

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) _____ (Means of injury)

23. Signature L. S. Markel M.D. (M. D. or other) _____
Address Poplar Bluff Mo Date signed _____

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

SUPPLEMENTARY

40678