

FILED DEC 28 1946

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 394

1. PLACE OF DEATH:

(a) County Maxion
(b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Marion Hotel 3
(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 Jackson 48
(c) City or town Kansas City 0
(If outside city or town limits, write "RURAL")
(d) Street No. Rural 3
(If rural, give location) 1
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME David Michael Neuszel

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

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

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

7. Birth date of deceased October 22 1946
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name Robert T. Neuszel

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

14. Maiden name Sulia Trost

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

16. (a) Informant Robert Neuszel
(b) Address Marion Hotel Hannibal Mo

17. (a) Burial (b) Date thereof NOV 22 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT. OLIVE T. C. M.

18. (a) Signature of funeral director James O'Donnell
(b) Address Hannibal Mo

19. (a) 12-9-46 (b) Dr. C. M. Luke
(Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 21
year 1946 hour _____ minute 8:30 P. M.

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

Immediate cause of death Intestinal Ill. Duration _____

Due to Ill

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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? 3

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

23. Signature James O'Donnell Date signed 11/22/46
Address Hannibal Mo

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

40154

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

33B

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..... *H. M. O'Connell*
Licensed Embalmer No..... *3889*
P. O. Address..... *Hannibal 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.

.. 7. 4. 11