

No. 2-45
1739
EX-7070

FILED JAN 16 1947

Registration District No. 76

Primary Registration District No. 3015

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Clinton

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

(c) Name of hospital or institution:
Cory Hook Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 weeks
(Specify whether years, months or days)

In this community 25 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clinton 25

(c) City or town Cameron
(If outside city or town limits, write "RURAL") 0

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Willie Neff

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 2 year 1947 hour _____ minute 1:00 M.

21. I hereby certify that I attended the deceased from Jan 2 1947 to Jan 3 1947
that I last saw he alive on Jan 1 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
Duration _____

4. Sex Female 5. Color or race W

6. (a) Single, widowed, married, divorced 2

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

7. Birth date of deceased: May 30 1875
(Month) (Day) (Year)

Due to _____

Due to _____

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

8. AGE:	Years	Months	Days	If less than one day
	<u>71</u>	<u>7</u>	<u>2</u>	_____ hr. _____ min.

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings _____
Of operations _____

Of autopsy _____

11. Industry or business _____

12. Name David Warner

13. Birthplace no record Ohio
(City, town, or county) (State or foreign country)

14. Maiden name _____

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

16. (a) Informant Ray Neff

(b) Address St. Joseph MO

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

(c) Place: burial or cremation Spaeland

18. (a) Signature of funeral director Poland Funeral Home
(b) Address Cameron

19. (a) 1-3-47 (b) Mrs. Willie Jones
(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) _____
(a) _____ (b) Means of injury _____

23. Signature M. D. [unclear] (M. D. or other) _____
Address Cameron Mo Date signed 1/3/47

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A-E
008233

**DISTRICT HEALTH OFFICE
Cameron, Mo.**

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

W. Nelson

Licensed Embalmer No. *4421*

P. O. Address

Cameron

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 DEATHState File No. *Jef*Registration District No. *75*Primary Registration District No. *3015*

Registrar's No. _____

1. PLACE OF DEATH:

(a) County *Clinton*
 (b) City or town *Cameron*
 (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 days3. (a) PRINT FULL NAME *Willie Jeff*

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 *wid*

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

7. Birth date of deceased *May 30*
(Month) (Day) (Year)8. AGE: Years *21* Months _____ Days _____ If less than one day _____ hr. _____ min.9. Birthplace _____ (City, town, or county) (State or foreign country) *MO*

10. Usual occupation _____

11. Industry or business _____

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) *1-3-47* (b) *Mrs Willie James*
(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 _____ Year *1947* Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;

that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

MOTHER FATHER

S-586