

FILED AUG 22 1947

State File No. \_\_\_\_\_

Registration District No. 43

Primary Registration District No. 5142

Registrar's No. 299

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

1. PLACE OF DEATH:

(a) County Butler

(b) City or town R.F.D. Neelyville  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Neely Trwp. 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 yrs.  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County Butler

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

(d) Street No. R.F.D.  
(If rural, give location)

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

3. (a) PRINT FULL NAME NELLIE MAY KIME

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 11th.  
year 1947 hour 04:00 minute \_\_\_\_\_ P. M.

4. Sex F. 5. Color or race W

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

6. (b) Name of husband or wife Henry Kime

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased: Sept. 4 1891  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 18 APRIL, 1947, to 11 AUG, 1947;  
that I last saw h.e. alive on 6 July, 1947;  
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocarditis

8. AGE: Years 55 Months 11 Days 7  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to: Nephritis, Chr. Arterial Hypertension

Due to: \_\_\_\_\_

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

10. Usual occupation Nurse

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Douglas M. Neal

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

14. Maiden name Sarah L. Bruce

15. Birthplace Wayne Co. Ill.  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Henry Kime

(b) Address R.F.D. Neelyville, Mo.

17. (a) Burial (b) Date thereof 8-12-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Paplar Bluff Mo.

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 \_\_\_\_\_

18. (a) Signature of funeral director Russell Mortuary

(b) Address Piggott Ark.

19. (a) Sperry (b) R. M. Neel  
(Date received local registrar) (Registrar's signature)

23. Signature Hester Harwell (M. D. or other) \_\_\_\_\_

Address Paplar Bluff, Mo. Date signed 12 Aug 1947

RECEIVED  
District Health Office No. 2,  
District File Number 827-1096  
Date Filed 8-18-47

AUG 2  
1947

**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.....

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.**