V. S. No. 2
50M—1/47
Rev. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

36766

State File No.

FILED NOV 6 1947

Registration District No. 323 Primary Registration District No. 6090 Registrar's No. 30

97
06

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

1. PLACE OF DEATH:
(a) County: SALINE
(b) City or town: LIBERTY TWSH (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Northeast of Sweet Springs (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution / (Specify whether years, months or days) In this community: 60 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: SALINE 97
(c) City or town: RURAL. LIBERTY TWSH 0 (If outside city or town limits, write "RURAL")
(d) Street No.: No. EDGE of LIBERTY 0 (If rural, give location)
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME: CHAS. WESLEY ONEAL
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: MARRIED
6. (b) Name of husband or wife: ROSE ONEAL
6. (c) Age of husband or wife if alive: 71 years
7. Birth date of deceased: FEB. (Month) 17. (Day) 1870 (Year)

8. AGE: Years 77 Months 8 Days 11 If less than one day hr. min.

9. Birthplace: Not Known (City, town, or county) Iowa (State or foreign country)
10. Usual occupation: ~~Farmer~~
11. Industry or business: FARMER
FATHER
12. Name: JAMES ONEAL
13. Birthplace: (City, town, or county) KY. (State or foreign country)
MOTHER
14. Maiden name: JULIA MATTHERN
15. Birthplace: (City, town, or county) IOWA (State or foreign country)
16. (a) Informant: MRS. ROSE ONEAL
(b) Address: SWEET SPRINGS
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10/30/47 (Month) (Day) (Year)
(c) Place: burial or cremation: FAIRVIEW CEMETERY
18. (a) Signature of funeral director: R. C. CARTER
(b) Address: SWEET SPRINGS, Mo
19. (a) 10/30/47 (Date received by local registrar) (b) Dolly Andrew (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 28 year 1947 hour 7:30 minute P M.
21. I hereby certify that I attended the deceased from 24 Oct, 1947, to Death, 19..., that I last saw him alive on 28 October, 1947, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Thrombosis	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy:	

PHYSICIAN — Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury
23. Signature: Joseph P. Dayle (M. D. or other) M. D.
Address: Sweet Springs Date signed: 10-29-47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number.....
Date Filed 11-5-47

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 R C Carter

Licensed Embalmer No. 8513

P. O. Address Sweet Springs 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.