

STANDARD CERTIFICATE OF DEATH

State File No. **29182**

No. 300
10.48

FILED AUG 28 1951

BIRTH NO. _____ REG. DIST. NO. **324** PRIMARY REG. DIST. NO. **3072** Registrar's No. **161**

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission). a. STATE Missouri b. COUNTY Saline	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN marshall		c. LENGTH OF STAY (in this place) 2 yrs.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 676 W. Thomas		d. STREET ADDRESS (If rural, give location) 676 W. Thomas	

3. NAME OF DECEASED (Type or Print)	a. (First) COLUMBUS	b. (Middle) C	c. (Last) NEAL	4. DATE OF DEATH (Month) (Day) (Year) August 23, 1951
-------------------------------------	----------------------------	----------------------	-----------------------	--

5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) unmarried	8. DATE OF BIRTH Feb. 2, 1875	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 15 MIN. Min.
--------------------	-------------------------------	---	--------------------------------------	---	------------------------	------------------------	-----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) minister	10b. KIND OF BUSINESS OR INDUSTRY church	11. BIRTHPLACE (State or foreign country) Illinois	12. CITIZEN OF WHAT COUNTRY? U.S.A
---	---	---	---

13a. FATHER'S NAME Alexander Neal	13b. MOTHER'S MAIDEN NAME Sarah Proctor	14. NAME OF HUSBAND OR WIFE _____
--	--	-----------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Wm H. W. Schofield	ADDRESS Beloit Kans.
--	-------------------------------------	---	-----------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 15 MIN
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Arterial Sclerosis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		3 yrs	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION 4/201	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------------	---	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
---	--	----------------------------------

22. I hereby certify that I attended the deceased from **8/23**, 19**51**, to **8/23**, 19**51**, that I last saw the deceased alive on **8/23**, 19**51**, and that death occurred at **7:10** a.m., from the causes and on the date stated above.

23a. SIGNATURE [Signature]	(Degree or title) U	23b. ADDRESS [Address]	23c. DATE SIGNED 8/24/51
-----------------------------------	----------------------------	-------------------------------	---------------------------------

24a. BURIAL CREMATION DATE Burial 8-25-51	24c. NAME OF CEMETERY OR CREMATORY mt. Horeb Cem.	24d. LOCATION (City, town, or county) (State) Saline Co. Mo.
--	--	---

DATE REC'D BY LOCAL REG. Aug 25-1951	REGISTRAR'S SIGNATURE [Signature]	385	25. FUNERAL DIRECTOR'S SIGNATURE Harry Hershberger	ADDRESS marshall, Mo.
---	--	-----	---	------------------------------

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

977

RECEIVED 8-27-51

DISTRICT HEALTH OFFICE No. 3

District File Number _____

Date Filed 8-27-51

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed Joseph R. Mackler

Licensed Embalmer No. 4571

P. O. Address Marshall, 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.