

No. 300
10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20151**
Registrar's No. **567**

FILED JUN 16 1952

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000**

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Arkansas b. COUNTY Carroll	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Green Forest	
d. FULL NAME OF HOSPITAL OR INSTITUTION Springfield Baptist Hospital		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) Charlie	b. (Middle) C.	c. (Last) O' Neal	4. DATE OF DEATH (Month) (Day) (Year) 6th 11 1952
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5. SEX Male	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept 25, 1872	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months 8 Days 16	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Broker	10b. KIND OF BUSINESS OR INDUSTRY Broker	11. BIRTHPLACE (State or foreign country) Carroll Co. Ark.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME William O'Neal	13b. MOTHER'S MAIDEN NAME Garrison	14. NAME OF HUSBAND OR WIFE Mollie O'Neal
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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 Mrs. Mollie O'Neal	ADDRESS
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 2 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Gen. Arteriosclerosis		
	DUE TO (c) Carcinoma of Prostate		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		10 yr.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 332 X 14	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **6/10 1952**, to **6/11 1952**, that I last saw the deceased alive on **6/11 1952**, and that death occurred at **9:00** m., from the causes and on the date stated above.

23a. SIGNATURE D. Callaway M.D. (Degree or title)	23b. ADDRESS Springfield Mo	23c. DATE SIGNED 6/11/52
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24a. BURIAL, CREMATION, REMOVAL Removal	24b. DATE 11 June 52	24c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery	24d. LOCATION (City, town or county) (State) Green Forest Ark.
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DATE REC'D BY LOCAL REG. 6-14-52	REGISTRAR'S SIGNATURE Edith Williamson Registrar	25. FUNERAL DIRECTOR'S SIGNATURE Nelson Funeral Home	ADDRESS Berryville Ark.
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(Licensed Embalmer's Statement on Reverse Side)

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

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 Charles M. Nelson

Licensed Embalmer No. ark # 815

P. O. Address Berryville, ark

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.