

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12318
Registrar's No. 107

FILED APR 23 1947

Registration District No. _____

Primary Registration District No. 3000

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Kirksville
(c) Name of hospital or institution Stuckler Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 weeks
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME GRACIE HARRIET NEELEY

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 MARRIED
6. (b) Name of husband or wife Everette E. Neeley 6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased June 23 1888
(Month) (Day) (Year)

8. AGE: Years 58 Months 9 Days 14 If less than one day hr. min.

9. Birthplace Adair Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Home

12. Name Alice Elyton
13. Birthplace Adair Co. Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Rachel Shelley
15. Birthplace Adair Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Everette E. Neeley
(b) Address Stahl, Mo.

17. (a) Burial (b) Date thereof Apr. 9, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Castle Cem.

18. (a) Signature of funeral director Glenn E. Kuntz, Son

(b) Address Green City, Mo.

19. (a) 4-16-47 (b) Walter Lambert
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Adair
(c) City or town Stahl
(If outside city or town limits, write "RURAL")
(d) Street No. ✓ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 6
year 1947 hour 3 minute 45 P.M.

21. I hereby certify that I attended the deceased from April 7
1947 to April 6 1947

that I last saw her alive on April 6 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Lympho-sarcoma
involvement Duration 3 wks.

Due to Chemo-therapy 1 wks.

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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)
(b) Means of injury _____

23. Signature W. P. Shipley (M. D. or other) MD
Address Kirksville Mo. Date signed 4-7-47

JUL 18 1947

APR 23 1947

RECEIVED
District Health Officer No. 10
4-47-669
APR 17 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 Archibald Wade

Licensed Embalmer No. 3037

P. O. Address Burdin 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.