

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

65-050896

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 53 Primary Registration District No. 3009 Registrar's No. 14

FILED JAN 18 1966

VS 300
Rev. 4/59

1 0161
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4 1
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9 4201
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12 90-0
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>CAPE GIRARDEAU</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before institution) a. STATE <u>Mo</u> b. COUNTY <u>CAPE GIRARDEAU</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>JACKSON</u>		Length of stay in 1b <u>10 YEARS</u>	c. CITY OR TOWN <u>JACKSON</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>314 S. HOPE</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>314 S. HOPE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY ELLNICE McNEELY</u>			4. DATE OF DEATH Month Day Year <u>DEC 28 1965</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 4, 1900</u>
9. AGE (last birthday) <u>65</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (City and state or country) <u>Fruitland, Mo</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>GEORGE McNEELY</u>	13b. MOTHER'S MAIDEN NAME <u>ADDIE CALDWELL</u>
14. NAME OF HUSBAND OR WIFE <u>-</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) <u>NO</u> <u>N/A</u>	
16. SOCIAL SECURITY NO. <u>N/A</u>		17. INFORMANT <u>MRS DENZIL Thompson</u> Address <u>JACKSON, Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Coronary artery sclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>Few minutes</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>12-5-53</u> to <u>12-28-65</u> and last saw her alive on <u>12-28-65</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>J. Jager, M.D.</u> (Degree or title)		22b. ADDRESS <u>Jackson, Mo.</u>	22c. DATE SIGNED <u>12-28-65</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>DEC 31, 1965</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PLEASANT HILL</u>	23d. LOCATION (City, town, or county) (State) <u>Fruitland, Mo</u>
24. FUNERAL DIRECTOR <u>J. N. Boudinot</u> ADDRESS <u>JACKSON, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>1-12-1966</u>	26. REGISTRAR'S SIGNATURE <u>James Kasten</u>

1-00
D-UP

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 _____
Signature of Student Embalmer

Signed *W. C. Crawford*

Licensed Embalmer No. 4327

P. O. Address Jackson, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.