

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24111
2721
Registrar's No. _____

AUG 14 1940 399
Registration District No. _____

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Kansas
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Vincent's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

8. (a) PRINT Infant Daughter of
FULL NAME Mr. & Mrs. Carl Neuhard

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 6. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 6 1940
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	--	--	--	<u>1 hour</u> min.

9. Birthplace Kansas City Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business None

12. Name Carl A Neuhard

13. Birthplace Pittsburg Pa.
(City, town, or county) (State or foreign country)

14. Maiden name Alice Rowan

15. Birthplace Pittsburg Pa.
(City, town, or county) (State or foreign country)

16. (a) Informant Carl Neuhard

(b) Address 1311 Broadway

17. (a) Burial (b) Date thereof July 8 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn

18. (a) Signature of funeral director J. W. Wagner

(b) Address Kansas City

19. (a) July 7, 1940 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City Missouri
(If outside city or town limits, write "RURAL")
(d) Street No. 1311 Broadway
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 7th
year 1940 hour 11 minutes _____ A. M.

21. I hereby certify that I attended the deceased from July 6 1940, to July 6 1940,
that I last saw her alive on July 6, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral meningitis
Due to Intra uterine mal development

Due to _____
Other conditions none
(Include pregnancy within 3 months of death)

Major findings: Of operations no
Of autopsy no

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) no
(b) Date of occurrence no
(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? no

While at work? no (Specify type of place) (e) Manner of injury _____
23. Signature J. W. Wagner (M. D. _____)
Address 1103 Grand Date signed 7/7/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

JUN 1 1941

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 Alvin R. Havenschild

Licensed Embalmer No. 4159

P. O. Address Kansas City 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, above space should be left blank.