

No. 2
12-45
5-17-39
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11768
Registrar's No. 812

FILED APR 15 1947
Registration District No. 317

Primary Registration District No. 2063

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 month
In this community 34 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Jessie L. Neff
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 George M. Neff
6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased May 10 1890
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
66 10 29 hr. min.

9. Birthplace: Excelsior Wisconsin
(City, town, or county) (State or foreign country)
10. Usual occupation Housewife

11. Industry or business ----
12. Name O. E. Winton
13. Birthplace Wisconsin
(City, town, or county) (State or foreign country)
14. Maiden name Mary Ann Trenor
15. Birthplace Wisconsin
(City, town, or county) (State or foreign country)

16. (a) Informant George M. Neff
(b) Address Berkeley, Missouri
17. (a) Burial (b) Date thereof 4/10/47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Lebanon

18. (a) Signature of funeral director White Funeral Home
(b) Address Ferguson, Missouri
19. (a) 4-10-47 (b) Leila G. Shaw
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town Berkeley
(If outside city or town limits, write "RURAL")
(d) Street No. 5th & Hancock
(If rural, give location)
(e) Citizen of foreign country? --- (Yes or No)
If yes, name country ---

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 8
year 1947 hour 4 minute 00 A.M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral Thrombosis
Cerebral art. sclerosis.
Due to 83 b
Other conditions (include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____
Duration 3 mths.
PHYSICIAN
Underline the cause to which death should be charged statistically.

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) Means of injury 0
Signature J. J. Jauron (M. D. or other) MD
Address Northway Bldg. St. Louis Date signed 4/17/47

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 L. M. Shute

Licensed Embalmer No. 2973

P. O. Address Ferguson, 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.