

FILED NOV 17 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37643**

BIRTH NO. _____ REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 5369 Registrar's No. 339

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY DeKalb	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Brooking Township		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fairport	
c. LENGTH OF STAY (in this place) 1 day		d. STREET ADDRESS (If rural, give location) None	
d. FULL NAME OF HOSPITAL OR INSTITUTION Rural 3			

3. NAME OF DECEASED (Type or Print) a. (First) Harry	b. (Middle) Edward	c. (Last) Neil	4. DATE OF DEATH (Month) (Day) (Year) Nov. 5 49
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug 24, 1884
9. AGE (In years last birthday) 65	IF UNDER 1 YEAR (Months) 2	IF UNDER 12 HRS. (Days) 11	IF UNDER 24 HRS. (Hours) 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Kansas	12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Andrew Jackson Neil	13b. MOTHER'S MAIDEN NAME Margaret Murry	14. NAME OF HUSBAND OR WIFE Bessie Neil
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs Ernest Ellis K.C.Mo.	ADDRESS RR#3
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 days 10 yrs (1 yr)
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Coronary insufficiency		
DUE TO (c) ✓		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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)	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 11-6, 1949, to 11-6, 1949, that I last saw the deceased alive on 11-6, 1949, and that death occurred at 10:30 P m., from the causes and on the date stated above.

23a. SIGNATURE D. McEubank M.D. (Degree or title)	23b. ADDRESS Raytown Mo.	23c. DATE SIGNED 11-7-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 11/7/49	24c. NAME OF CEMETERY OR CREMATORY Fairport, Mo. Cemetery	24d. LOCATION (City, town, or county) (State) Fairport, Mo.
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DATE REC'D BY LOCAL REG. Nov 7-1949	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS Raytown Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Nov-14-49

NOV 14 RECD

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. 325

working under my personal supervision.

Student Gail L. Slack
Student Embalmer

Signed E. Clark Hegert

Licensed Embalmer No. 3983

P. O. Address Raytown 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.