

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 32255

FILED SEP 18 1951

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 322 PRIMARY REG. DIST. NO. 3021 Registrar's No. 35

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Saline	
b. CITY (If outside corporate limits, write RURAL and give township) Slater	c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) Slater	0971
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) Maple St.	

3. NAME OF DECEASED (Type or Print) a. (First) Ulysses b. (Middle) Solomon c. (Last) Neff			4. DATE OF DEATH (Month) (Day) (Year) Sept. 10 '51				
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH March, 29, '72	9. AGE (In years last birthday) 79	10. MONTHS 5	11. DAYS 11	12. IF UNDER 18 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Cole Camp, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.	

13a. FATHER'S NAME William Neff		13b. MOTHER'S MAIDEN NAME Margaret Cott		14. NAME OF HUSBAND OR WIFE none	
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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 ADDRESS Russell Neff, Bonner Springs, Kan.			
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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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion			INTERVAL BETWEEN ONSET AND DEATH
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
		DUE TO (b) _____			
		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) 4201
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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 Sept. 13, 1951, 1951, that I last saw the deceased alive on Sept. 10, 1951, and that death occurred at 11:30 p. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) R. L. Lawless Coroner Saline P33		23b. ADDRESS Marshall Mo.		23c. DATE SIGNED 9-18-51	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9/13/51	24c. NAME OF CEMETERY OR CREMATORY Slater City	24d. LOCATION (City, town, or county) (State) Slater, Mo
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DATE REC'D BY LOCAL REG. 9/13/51	REGISTRAR'S SIGNATURE Mrs. Earl C. Metz	25. FUNERAL DIRECTOR'S SIGNATURE Hill Brothers	ADDRESS
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Probably had been dead 48 hours when found.  
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD—

RECEIVED 9-17-51

DISTRICT HEALTH OFFICE No. 3

District File Number \_\_\_\_\_

Date Filed 9-17-51

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 .....  
Student Embalmer

Signed A. C. Hill

Licensed Embalmer No. 3090

P. O. Address Staten, 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.