

FILED OCT 15 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **32696**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1040

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Joseph</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City 3008</u>	
c. LENGTH OF STAY (in this place) <u>214 days</u>		d. STREET ADDRESS (If rural, give location) <u>Jackson County Court</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital # 2</u>			

3. NAME OF DECEASED (Type or Print) <u>Katherine</u> (First) (Middle) (Last) <u>Neil</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>10 8 1951</u>		
--	--	--	---	--	--

5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Unknown</u>		9. AGE (In years last birthday) <u>about 71</u>		10. IF UNDER 1 YEAR: Months Days		10. IF UNDER 2 HRS: Hours Min.	
----------------------	--	-------------------------------	--	--	--	------------------------------------	--	---	--	----------------------------------	--	--------------------------------	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>		11. BIRTHPLACE (State or foreign country) <u>America</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
---	--	---	--	---	--	---	--

13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Unknown</u>	
--------------------------------------	--	---	--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>nil</u>		17. INFORMANT'S SIGNATURE, OR NAME AND ADDRESS <u>C. Cassine, State Hospital # 2</u>	
---	--	---------------------------------------	--	---	--

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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>no. of years</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Diabetes Mellitus</u>				" " "	
		DUE TO (c)					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>arterosclerosis</u>				<u>10 yrs</u>	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>260X</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
------------------------	--	---	--	---	--

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)	
--	--	--	--	---	--

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?	
---	--	--	--	----------------------------	--

22. I hereby certify that I attended the deceased from Feb 21, 1951, to Oct 8, 1951, that I last saw the deceased alive on October 8, 1951, and that death occurred at 7:55 a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>C. Cassine</u> (Degree or title) <u>M.D.</u>		23b. ADDRESS <u>State Hospital # 2</u>		23c. DATE SIGNED <u>10-8-1951</u>	
---	--	---	--	--------------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>10-8-51</u>		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) <u>Hicksville, Mo.</u>	
---	--	-----------------------------	--	------------------------------------	--	---	--

DATE REC'D BY LOCAL REG. <u>October 10, 1951</u>		REGISTRAR'S SIGNATURE <u>Carl C. Casel</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Newton Burman</u>		ADDRESS <u>Tennal Home, St. Joseph, Mo.</u>	
---	--	---	--	--	--	--	--

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

117

**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

*Eugene Wood*

Licensed Embalmer No. *3804*

P. O. Address *319 So 10th St, St Joseph, 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.