

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3411**

No. 300
10-48

FILED FEB 10 1956

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **155**

1. PLACE OF DEATH a. COUNTY St Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Koch, Mo.		c. LENGTH OF STAY (In this place) 5 years	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION Robert Koch Hospital		e. STREET ADDRESS (If rural, give location) 9th and Market (stag Hotel)	

3. NAME OF DECEASED (Type or Print) a. (First) James b. (Middle) Tidwell c. (Last) Neely	4. DATE OF DEATH (Month) (Day) (Year) 1 13 56
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Never married	8. DATE OF BIRTH 2-21-82	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	10b. KIND OF BUSINESS OR INDUSTRY Labor	11. BIRTHPLACE (City and State or Foreign Country) Nashville, Tenn.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME William Neely	13b. MOTHER'S MAIDEN NAME Laura Williams	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. Nil	17. INFORMANT'S SIGNATURE OR NAME Records Koch Hospital, Koch, Mo.	ADDRESS _____
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Pulmonary Tuberculosis		8 years
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cirrhosis of Liver		10 years

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION 002X	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) _____
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 **1-23**, 19**51**, to **1-13**, 19**56**, that I last saw the deceased alive on **1-13**, 19**56**, and that death occurred at **10:30a** m., from the causes and on the date stated above.

23a. SIGNATURE H.A. Harris (Degree or title) MD	23b. ADDRESS Koch Hospital, Koch, Mo	23c. DATE SIGNED 1-15-56
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24a. BURIAL OR CREMATION (Specify) _____	24b. DATE 1-18-56	24c. NAME OF CEMETERY OR CREMATORY Memorial Pk. Cem.	24d. LOCATION (City, town, or county) (State) St. Louis, County, Mo.
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DATE REC'D BY LOCAL REG. 1-18-56	REGISTRAR'S SIGNATURE Debert B. Domb...	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington,
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Dr. (Licensed Embalmer's Statement on Reverse Side)

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

APR 12 1933

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.....
Signature of Student Embalmer

Signed.....
Licensed Embalmer No.....

No Embalmer
Autobalmer

P. O. Address.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.