

FILED MAR 22 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11201

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2254**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution residence before admission). a. STATE <b>Illinois</b> b. COUNTY <b>St. Clair</b>		
b. CITY (If outside corporate limits, write RURAL and give town or town <b>St. Louis, Mo.</b> )		c. LENGTH OF STAY (in this place) <b>9 days</b>	c. CITY OR TOWN <b>O'Fallon</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>			e. STREET ADDRESS (If rural, give location) <b>319 W. 3rd St 61208</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>August</b> b. (Middle) <b>NMN</b> c. (Last) <b>Neff</b>			4. DATE OF DEATH <b>March 2, 1956</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>Apr. 20-1892</b>		9. AGE (In years last birthday) <b>63</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laboer - Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Feed Mill</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>German Town, Ill</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
13a. FATHER'S NAME <b>Peter Neff</b>		13b. MOTHER'S MAIDEN NAME <b>Philomenia Heideman</b>		14. NAME OF HUSBAND OR WIFE <b>MARGARET Neff</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>354-10-9235</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Margaret Neff</b> ADDRESS <b>O'Fallon Ill</b>		
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		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Aortic Stenosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			DUE TO (b) <b>Arteriosclerotic Heart Disease</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			DUE TO (c)		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>420.0</b>			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (Min.)		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 <b>Feb. 22, 1956</b> , to <b>Mar 2, 1956</b> , that I last saw the deceased alive on <b>Mar. 2, 1956</b> and that death occurred at <b>2:30A m.</b> , from the causes and on the date stated above.					
23a. SIGNATURE (Type name or title) <b>C. J. Vermillion, M.D.</b>			23b. ADDRESS <b>BARNES HOSPITAL</b>		23c. DATE SIGNED <b>3/2/56</b>
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <b>3-3-56</b>	24c. NAME OF CEMETERY OR CREMATORY <b>O'Fallon</b>		24d. LOCATION (City, town, or county) (State) <b>ILL</b>
DATE REC'D BY LOCAL REG. <b>MAR 3 1956</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>M. Walkersberger</b> ADDRESS <b>O'Fallon Ill</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

---

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, *Frank Proff*.....

Licensed Embalmer No. *4*.....

P. O. Address *St. Louis*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.