

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43611

STATE FILE NUMBER

FILED DEC 27 1956

Registration District No.

318

Primary Registration District No.

1003

Registrar's

11163

Health, Welfare and Public Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>MO. PACIFIC HOSPITAL</u> <u>ST. LOUIS - MO.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST. LOUIS,</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MO. PACIFIC HOSP</u>		Length of stay in lb <u>17 days</u>	d. STREET ADDRESS <u>4332 SOUTH 37th ST.</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>SA MUEL</u> Middle <u>O</u> Last <u>NEILL</u>			4. DATE OF DEATH Month <u>DEC.</u> Day <u>6</u> Year <u>1956</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 24, 1875</u>
9. AGE (In years last birthday) <u>80</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BEACON PAPER, CO.</u>	11. BIRTHPLACE (City and state or country) <u>LOGAN CO. KY.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>WILLIAM R. NEILL</u>	
14. MOTHER'S MAIDEN NAME <u>EMMA YOUNG</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u> <u>NONE</u>	
16. SOCIAL SECURITY NO. <u>488-01-6533</u>		17. INFORMANT <u>FRANK NEILL-CLARIDGE HOTEL</u> Address <u>18TH + LOCUST</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ADENOCARCINOMA, HEAD OF PANCREAS</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>157X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>18 wks</u>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY	
20g. STATE			
21. I attended the deceased from <u>Sept 16 1956</u> to <u>DEC 6 1956</u> and last saw her alive on <u>DEC 6 1956</u> Death occurred at <u>6:45</u> <u>1A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>John T. Vandover MD</u> (Degree or title)		22b. ADDRESS <u>1504 So Grand</u>	
22c. DATE SIGNED <u>12/6/56</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	
<u>REMOVAL (RAIL) 12-7-56</u>		<u>12-7-56</u>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
		<u>KNOXVILLE, TENN.</u>	
24. FUNERAL DIRECTOR <u>KRIEGSHAUSER 42285 KINGSHIGHWAY</u>		25. DATE RECD. BY LOCAL REG. <u>DEC 6 1956</u>	
26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>			

(Licensed Embalmer's Statement on Reverse Side)

m 83

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..... *Richard W. Stovess*

Licensed Embalmer No. *40*

P. O. Address

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.