

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3318**

No. 300
10.48

FILED JAN 15 1957

BIRTH NO. _____ REG. DIST. NO. **322** PRIMARY REG. DIST. NO. **3071** Registrar's No. **18**

1. PLACE OF DEATH a. COUNTY SALINE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY SALINE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SLATER		c. CITY OR TOWN SLATER	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 16 YRS		e. STREET ADDRESS (If rural, give location) WALNUT ST. 09710	
d. FULL NAME OF HOSPITAL OR INSTITUTION WALNUT ST.			
3. NAME OF DECEASED (Type or Print)	a. (First) RICHARD HARVEY	b. (Middle) NEFF	c. (Last) NEFF
4. DATE OF DEATH	(Month) JAN	(Day) 9	(Year) 1957
5. SEX Male	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JAN. 6 1881
9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months 0 Days 3	IF UNDER 2 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER	10b. KIND OF BUSINESS OR INDUSTRY BARBER	11. BIRTHPLACE (City and State or Foreign Country) SALINE COUNTY MO	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME WILLIAM NEFF	13b. MOTHER'S MAIDEN NAME SARAH COTT	14. NAME OF HUSBAND OR WIFE BESSIE NEFF	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 495-36-5498	17. INFORMANT'S SIGNATURE OR NAME Mrs. Harvey Neff, Slater, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis		INTERVAL BETWEEN ONSET AND DEATH But	
ANTECEDENT CAUSES		DUE TO (b) Nephritic Interstitial	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) Pulmonary Edema	
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION None		20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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)	594X
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 12-26 , 19 57 to 1-9 , 19 57 , that I last saw the deceased alive on 1-9 , 19 57 , and that death occurred at 7:55 p. m., from the causes and on the date stated above.			
23a. SIGNATURE H. Lockwood M.D.	(Degree or title)	23b. ADDRESS Slater Mo	23c. DATE SIGNED 1-11-56
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1/11/1957	24c. NAME OF CEMETERY OR CREMATORY Slater	24d. LOCATION (City, town, or county) (State) Slater Mo
DATE REC'D BY LOCAL REG. 1-12-57	REGISTRAR'S SIGNATURE Mrs. Earl C. Metz	25. FUNERAL DIRECTOR'S SIGNATURE W. J. Haines, Slater, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

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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 *Walter J. Haines, Jr.*

Licensed Embalmer No. *455*

P. O. Address *States*

**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.**