

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAR 20 1957

State File No. 9000

BIRTH NO. _____		REG. DIST. NO. <u>146</u>		PRIMARY REG. DIST. NO. <u>3026</u>		Registrar's No. <u>106</u>					
1. PLACE OF DEATH a. COUNTY <u>Jackson</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>Independence</u>				c. LENGTH OF STAY (in this place) <u>2 WKS</u>				c. CITY OR TOWN <u>Independence</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Independence San & Hosp</u>				e. STREET ADDRESS (If rural, give location) <u>138 West Sea</u>				f. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Anna</u>			b. (Middle) <u>Maude</u>			c. (Last) <u>Neff</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Mar 14 1957</u>		
5. SEX <u>Fm</u>		6. COLOR OR RACE <u>Wh</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Oct 9 1889</u>		9. AGE (In years last birthday) <u>68</u>		<input type="checkbox"/> UNDER 1 YEAR <input type="checkbox"/> UNDER 2 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY _____				11. BIRTHPLACE (City and State or Foreign Country) <u>Blue Springs Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Wallace Shrout</u>				13b. MOTHER'S MAIDEN NAME <u>Lavina Martin</u>				14. NAME OF HUSBAND OR WIFE <u>Oscar Neff</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>NO</u>				16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Oscar Neff 138 w Sea Independence Mo</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>Primary adenocarcinoma of uterus with extensive metastasis</u> ANTECEDENT CAUSES _____ Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. _____ DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____ INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>							
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>same</u>						20. AUTOPSY? <u>2</u> 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) <u>Independence Mo</u>							
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 <u>June 15, 1947</u> , to <u>March 14, 1957</u> , that I last saw the deceased alive on <u>March 13, 1957</u> , and that death occurred at <u>2:15 A.M.</u> , from the causes and on the date stated above.											
23a. SIGNATURE (Degree or title) <u>W. H. Hickerson M.D.</u>				23b. ADDRESS <u>604 W. Maple Independence, Mo.</u>				23c. DATE SIGNED <u>3/14/57</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>3-16-1957</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Blue Springs</u>		24d. LOCATION (City, town, or county) (State) <u>Blue Springs Mo</u>					
DATE REC'D BY LOCAL REG. <u>3-16-57</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Webb Funeral Home Blue Springs Mo</u>					

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

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MAR 18 1957

APR 4 1957

MAY 9 1958

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 *R. Webb*

Licensed Embalmer No. *225*

P. O. Address *Blue spr*

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.