

Health, Welfare, Public Service

FILED OCT 9 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32067
STATE FILE NUMBER
Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4377

300
-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 817 Jefferson		d. STREET ADDRESS (If outside, give location) 817 Jefferson	
3. NAME OF DECEASED (Type or print) First Middle Last Hugo R. Neff		4. DATE OF DEATH Month Day Year Sept. 19, 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		11. BIRTHPLACE (City and state or country) Colorado	12. CITIZEN OF WHAT COUNTRY? U S. A.
13a. FATHER'S NAME J. W. Neff		13b. MOTHER'S MAIDEN NAME Agnes N. Korfhage	14. NAME OF HUSBAND OR WIFE Ruth Neff
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war(s) dates of service) W. W. #1 W. W. #1		16. SOCIAL SECURITY NO. 499-07-2210	17. INFORMANT Address Mrs. Ruth Neff 817 Jefferson K. M. Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Ventricular Failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Chronic Regurgitation - DUE TO (c) 4211			INTERVAL BETWEEN ONSET AND DEATH 1 hour years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <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 STATE	
21. I attended the deceased from Feb. 1947 to 9-19-57 and last saw him alive on 9-12-57 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) W. M. Ketcham M.D.		22b. ADDRESS KC Mo.	22c. DATE SIGNED 9-19-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 9-21-57	23c. NAME OF CEMETERY OR CREMATORY D. W. Newcomers	23d. LOCATION (City, town, or county) (State) Kansas City; Missouri
24. FUNERAL DIRECTOR Stine & McClure		25. DATE RECD. BY LOCAL REG. 9-20-57	26. REGISTRAR'S SIGNATURE Reva Minshall

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
W. M. Ketcham

All diseases in Part I must be causally related.

KP
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Wa. 12/20/08
will be in office at 11:30 & 1 P.M.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
X by me, or by, Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed *William M. Turner*

Licensed Embalmer No. *4648*

P. O. Address *Kansas City*

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.