

STANDARD CERTIFICATE OF DEATH

FILED NOV 18 1957

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 1100

Health,
& Welfare
Public
Service

S. 300

1-57

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. Missouri b. COUNTY Texas	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		c. CITY OR TOWN Cabool	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR Mercy Hosp. INSTITUTION		d. STREET ADDRESS (If outside, give location)	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First LAURA Middle MAE Last NEFF		Month Nov. Day 12 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Greene County, Mo.
13a. FATHER'S NAME Bateman Stevens		13b. MOTHER'S MAIDEN NAME Armanda Carter	14. NAME OF HUSBAND OR WIFE Cabool, Mo.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service). No		16. SOCIAL SECURITY NO. No	17. INFORMANT Neal Neff
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arterio-sclerosis - generalized.			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 331X			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <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 Nov 12 and last saw her alive on Nov 11, 1957 Death occurred at 2:45 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) John Williams M.D.		22b. ADDRESS Springfield	
22c. DATE SIGNED 11-13-57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11/15/57	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cem.	23d. LOCATION (City, town, or county) (State) Bolivar, Mo.
24. FUNERAL DIRECTOR Elliott-Gentry Funeral Home		25. DATE RECD. BY LOCAL REG. 11-14-57	26. REGISTRAR'S SIGNATURE John Williams

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

JAN 2 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 *H. M. Cannon*

Licensed Embalmer No. *2727*
P. O. Address *Springfield, Mo.*

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.