

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-024398

STATE FILE NUMBER

FILED JUN 17 1958

Registration District No. 360

Primary Registration District No. 6225

Registrar's No. 88

5. 300  
1-57

2

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Cass</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Washington Township</u> OR TOWN Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Harrisonville</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital #3</u> INSTITUTION Length of stay in lb <u>2 1/2</u> <u>5</u> <u>1/2</u> <u>4</u> <u>1/2</u> <u>5</u> <u>1/2</u>		d. STREET ADDRESS (If outside, give location) <u>Route #2</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle Last <u>NEILL</u>		4. DATE OF DEATH Month <u>6</u> Day <u>6</u> Year <u>1958</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/8/1883</u>
9. AGE (In years) <u>75</u> Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Kentucky</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>John P. Neill</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Young</u>	14. NAME OF HUSBAND OR WIFE <u>Single</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give year or dates of service) <u>no</u> <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT <u>Hospital records - Nevada</u> Address
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>Arteriosclerosis</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)			INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>4500</u>
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.) <u>None</u>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		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 STATE	
21. I attended the deceased from <u>12/31/56</u> to <u>6/6/58</u> and last saw <sup>her</sup> him alive on <u>6/6/58</u> Death occurred at <u>8 30 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>George Eiker</u> (Degree or title)		22b. ADDRESS <u>M. D. State Hospital No 3</u>	
22c. DATE SIGNED <u>6/6/58</u>		22d. LOCATION (City, town, or county) (State) <u>Cass Mo</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>6-8-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Council Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Council Mo</u>
24. FUNERAL DIRECTOR <u>Loramus Clark</u>		25. DATE RECD. BY LOCAL REG. <u>6-10-1958</u>	26. REGISTRAR'S SIGNATURE <u>Anna E. Ferry</u>

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 *Cramer Clark* .....

Licensed Embalmer No. *3257* .....

P. O. Address *Kingston* .....

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.