

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-041036

FILED VS DEC 9 1959

STATE FILE NUMBER

Registration District No. 224 Primary Registration District No. 3046 Registrar's No. _____

ENDED

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTEAU</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>CALLAWAY</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CALIFORNIA</u> | | c. CITY OR TOWN <u>PORTLAND</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>HALL Nursing Home</u> | | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

| | | | | | |
|--|--|--|---|--|--|
| 3. NAME OF DECEASED (Type or print) First <u>SPARRELL</u> Middle <u>E.</u> Last <u>NEAL</u> | | | 4. DATE OF DEATH Month <u>Dec.</u> Day <u>7</u> Year <u>1959</u> | | |
|--|--|--|---|--|--|

| | | | | | | |
|-----------------|---------------------------|---|------------------------------------|----------------------------------|--|--|
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-16-1878</u> | 9. AGE (last birthday) <u>81</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
|-----------------|---------------------------|---|------------------------------------|----------------------------------|--|--|

| | | | |
|--|--|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gen. mose store</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>STOREKEEPER</u> | 11. BIRTHPLACE (City and state or country) <u>PORTLAND, MO.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u> |
|--|--|---|---|

| | | |
|---------------------------------------|---|--|
| 13a. FATHER'S NAME <u>George Neal</u> | 13b. MOTHER'S MAIDEN NAME <u>AMANDA Blackburn</u> | 14. NAME OF HUSBAND OR WIFE <u>MARY E. NEAL.</u> |
|---------------------------------------|---|--|

| | | |
|--|--|---|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | 16. SOCIAL SECURITY NO. <u>UNKNOWN</u> | 17. INFORMANT Address <u>HALL Nursing Home Records, California, MO.</u> |
|--|--|---|

| | | |
|---|-------------------------------------|--|
| 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>Cerebral accident.</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>15 months</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Arterio-sclerosis</u> | |
| | DUE TO (c) _____ | |

| | |
|--|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition (as in PART I (a)) <u>Chronic Prostatitis</u> | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
|--|--|

| | | |
|--|---|--|
| 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 _____ 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 Dec 1 1959 to Dec 7 59 and last saw him alive on Dec 1 1959
Death occurred at 8:15 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

| | | |
|---|--------------------------------------|------------------------------------|
| 22a. SIGNATURE (Degree or title) <u>Edgar A. Kubo M.D.</u> | 22b. ADDRESS <u>California MO</u> | 22c. DATE SIGNED <u>12/7/59</u> |
|---|--------------------------------------|------------------------------------|

| | | | |
|--|----------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>Dec. 9, 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Portland Cem.</u> | 23d. LOCATION (City, town, or county) (State) <u>Portland, MO.</u> |
|--|----------------------------------|--|---|

| | | |
|--|--|--|
| 24. FUNERAL DIRECTOR <u>Maespin Funeral Home, Fulton, MO.</u> | 25. DATE RECD. BY LOCAL REG. <u>12/7/59</u> | 26. REGISTRAR'S SIGNATURE <u>Helena Papejoy</u> |
|--|--|--|

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Marshall C. Black

Licensed Embalmer No. 4713

P. O. Address Fulton, Pa.

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.