

Dept. Health,
Inc., & Welfare
U. S. Public
Health Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

=60-020375

STATE FILE NUMBER

FILED VS JUN 15 1960

Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 113

V. S. 300
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <u>Phelps</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Holt</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rolla</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Mound City</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>Phelps Co. Hosp. 1</u>		Length of stay in lb <u>6 days</u>	d. STREET ADDRESS (If outside, give location) <u>None</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ide</u> Middle <u>May</u> Last <u>O'Neal</u>			4. DATE OF DEATH Month <u>June</u> Day <u>9</u> Year <u>1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 22 1875</u>	9. AGE (In years last birthday) <u>85</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Fairfax Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13a. FATHER'S NAME <u>Alfred Angel</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Anna Christian</u>		14. NAME OF HUSBAND <u>Samuel O. P. O'Neal Dead.</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>None</u>	17. INFORMANT <u>Mrs Helen Walker</u> Address <u>Cuba, Mo</u>		
18. CAUSE OF DEATH (Not more than one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 yr (?)</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Age</u>				DUE TO (c) <u>4201</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Blural effusion.</u>				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 <u>6-3-60</u> to <u>6-9-60</u> and last saw her ^{him} alive on <u>6-8-60</u> Death occurred at <u>AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Name or title) <u>E. E. Feind, M.D.</u>			22b. ADDRESS <u>Rolla Mo</u>		22c. DATE SIGNED <u>6-9-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Reburial Burial</u>	23b. DATE <u>June 10 1960</u>	23c. NAME OF CEMETERY <u>Pleasant Ridge</u>		23d. LOCATION (City, town, or county) (State) <u>Fairfax Mo</u>	
24. FUNERAL DIRECTOR <u>Norman C. Hoener</u>		ADDRESS <u>Cuba, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>June 9, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Nadene L. Stoll</u>

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

MEDICAL CERTIFICATION

(Licensed Embalmer's Statement on Reverse Side)

VS DEC 20 1960

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 Norman E. Haener

Licensed Embalmer No. 4673

P. O. Address Cuba, 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.