

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-033030
STATE FILE NUMBER

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4649

FILED OCT 4 1961

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		Length of stay in 1b Life time	c. CITY OR TOWN Kansas City Mo. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2501 Flora		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2501 Flora Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First William Middle Neely Last Neely			4. DATE OF DEATH Month 9 Day 14 Year 61
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH -
9. AGE (last birthday) 61		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) Retired Packing House		10b. KIND OF BUSINESS OR INDUSTRY Wilson	11. BIRTHPLACE (City and state or country) Kansas City, Mo.
12. CITIZEN OF WHAT COUNTRY U. S. A		13a. FATHER'S NAME John Neely	
13b. MOTHER'S MAIDEN NAME Angeline Balthron		14. NAME OF HUSBAND OR WIFE Ada F. Neely	
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. 17. INFORMANT Ada F. Neely 1934 So. 38th K. C. K	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Starvation, Cachexia & Dehydration			INTERVAL BETWEEN ONSET AND DEATH Few days
DUE TO (b) Carcinoma of the Stomach			Months
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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 June 20, 1961 to 9-14-61 and last saw him alive on 9-14-61		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) George H. Taft, M.D.		22b. ADDRESS 2204 E. 18 th.	22c. DATE SIGNED 9-18-61
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-18-61	23c. NAME OF CEMETERY OR CREMATORY Maple Hill	23d. LOCATION (City, town, or county) (State) Kansas City Kansas
24. FUNERAL DIRECTOR Jones & Stevens 2315 Linwood		25. DATE RECD. BY LOCAL REG. 9-18-61	26. REGISTRAR'S SIGNATURE Ruth Long

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
George H. Taft

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.