

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-042819

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5845

FILED DEC 10 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF William D. Hoalder Medical Certification

USE BLACK INK OR TYPEWRITER RIBBON

SHOULD READ

ITEM NO.

1. PLACE OF BIRTH a. COUNTY <u>Jackson</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>60 years</u>	c. CITY OR TOWN <u>Kansas 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>Research Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1507 EAST 8th ST.</u>		
3. NAME OF DECEASED (Type or print) First <u>Daisie D.</u> Middle <u>Neal</u> Last <u>Neal</u>			4. DATE OF DEATH Month <u>November</u> Day <u>19</u> Year <u>1962</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 15, 1882</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>VINCENT HAIR Co.</u>	11. BIRTHPLACE (City and state or country) <u>CLINTON, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>Albert 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>—</u>	17. INFORMANT Address <u>RON TAYLOR 5050 Oak ST. K.P. 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>Hypostatic pneumonia - Infected Dental Abscess</u> DUE TO (b) <u>Fractured Rt hip</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						
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 <u>7 Nov 1962</u> to <u>Death</u> and last saw her alive on <u>11/19/62</u> Death occurred at <u>4:15</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>William D Hoalder MD</u>			22b. ADDRESS <u>6400 Prospect K.P. Mo</u>		22c. DATE SIGNED <u>11/20/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>NOV. 21, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Clinton Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Clinton, Missouri</u>		
24. FUNERAL DIRECTOR <u>Muehlebach</u>		ADDRESS <u>6800 TRUST</u>	25. DATE RECD. BY LOCAL REG. <u>11-20-62</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>		

~~Dr. Carl Jones~~
~~Angels Bldg. 1st Floor~~
~~W 2-8227 E 3-2285~~

Dr. Hodley

6:400 Prospect after 11:00 AM Tues.

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 R. E. Nichols

Licensed Embalmer No. 4997

P. O. Address R. E. Nichols

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.