

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-026149

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

6805

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. \_\_\_\_\_

**FILED JUL 5 1963**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>St. Louis</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>De Paul Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY _____ c. CITY OR TOWN <u>St. Louis, Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>1092 So. Taylor</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First <u>Lina-Belle</u> Middle <u>Mo</u> Last <u>Neely</u>			<b>4. DATE OF DEATH</b> Month <u>June</u> Day <u>28</u> Year <u>1963</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>8/25/1889</u>	<b>9. AGE</b> (last birthday) <u>73</u>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____

<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> 	<b>11. BIRTHPLACE</b> (City and state or country) <u>Missouri</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>		
<b>13a. FATHER'S NAME</b> <u>Marion Coley</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Chilton</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>John Mc Neely</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> _____		<b>17. INFORMANT</b> Address <u>Jean Patti, 1740 So. Vandeventer Ave.</u>	

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Chronic Pyelonephritis</u> DUE TO (c) <u>6000</u>		INTERVAL BETWEEN ONSET AND DEATH <u>one week</u>  <u>15 years</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic Heart Disease</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT SUICIDE HOMICIDE</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
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<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	<b>20f. CITY, TOWN, OR LOCATION</b> _____ COUNTY _____ STATE _____
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21. I attended the deceased from July 1954 to June 1963 and last saw <sup>(her)</sup> him alive on June 28, 1963.  
 Death occurred at 4:15 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22. SIGNATURE</b> (Degree or title) <u>Robert M. Launch M.D.</u>		<b>22b. ADDRESS</b> <u>52 Maryland Plaza</u>		<b>22c. DATE SIGNED</b> <u>29 June 1963</u> (date)	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Removal</u>	<b>23b. DATE</b> <u>6/29/1963</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Fredericktown Cemetery</u>	<b>23d. LOCATION</b> (City, town, or county) <u>Fredericktown, Missouri</u>		
<b>24. FUNERAL DIRECTOR</b> <u>Arthur J. Donnelly</u>		<b>ADDRESS</b> <u>3840 Lindell Blvd.</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>JUN 29 1963</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Loard Smith, M.D.</u>

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

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59

USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Mr. Robert Lammick  
52 Maryland Plaza  
F.O. 7-8844  
after 8:15 am  
but call first!

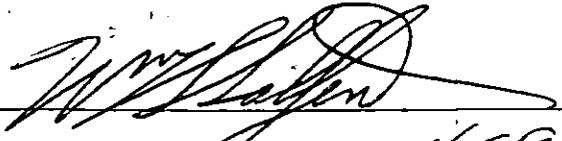
STATEMENT BY LICENSED EMBALMER

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. 4699

P.O. Address 3840 Linden

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.