

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-046892
STATE FILE NUMBER

Registration District No. 4 Primary Registration District No. 5023 Registrar's No. 117

FILED DEC 26 1963

DO NOT WRITE ON THIS STUB

AMENDED

<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Atchison</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clay Twp.</u> Length of stay in 1b _____</p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Rest Pleasant View Home</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>		<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Missouri</u> b. COUNTY <u>Atchison</u></p> <p>c. CITY OR TOWN <u>Rock Port</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>none</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED First Middle Last</p> <p><u>Nellie Crew Neal</u></p>		<p>4. DATE OF DEATH Month Day Year</p> <p><u>12 14 1963</u></p>	
<p>5. SEX</p> <p><u>Female</u></p>	<p>6. COLOR OR RACE</p> <p><u>White</u></p>	<p>7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH</p> <p><u>5-6-1871</u></p>
<p>9. AGE (last birthday) <u>92</u></p>		<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p><u>Housekeeper</u></p>	<p>10b. KIND OF BUSINESS OR INDUSTRY</p> <p><u>Own Home</u></p>
<p>11. BIRTHPLACE (City and state or country)</p> <p><u>Mt. Moria. Mo.</u></p>		<p>12. CITIZEN OF WHAT COUNTRY</p> <p><u>US</u></p>	
<p>13a. FATHER'S NAME</p> <p><u>Jacob Crew</u></p>		<p>13b. MOTHER'S MAIDEN NAME</p> <p><u>Unknown</u></p>	
<p>14. NAME OF HUSBAND OR WIFE</p> <p><u>Abraham Neal (Dec)</u></p>		<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)</p> <p><u>no none</u></p>	
<p>16. SOCIAL SECURITY NO.</p> <p><u>[redacted]</u></p>		<p>17. INFORMANT Address</p> <p><u>Mrs Vivian Miller, Fairfax, Mo.</u></p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Pneumonia</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Senility & Cerebral Arteriosclerosis</u></p> <p>DUE TO (c) _____</p>			<p>INTERVAL BETWEEN ONSET AND DEATH</p> <p><u>4 days</u></p>
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p>			<p>PART III. If deceased was female was there a pregnancy in last 90 days.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>	<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>	
<p>20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year</p>			
<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>			
<p>21. I attended the deceased from <u>July 19 61</u> to <u>12-14-63</u> and last saw her alive on <u>12-14-63</u></p> <p>Death occurred at <u>8:45</u> A.M. on the date stated above, and to the best of my knowledge, from the causes stated.</p>			
<p>22a. SIGNATURE (Degree or title)</p> <p><u>Wallace Carpenter MD</u></p>		<p>22b. ADDRESS</p> <p><u>Rock Port mo</u></p>	
<p>22c. DATE SIGNED</p> <p><u>12-14-63</u></p>		<p>22d. BURIAL, CREMATION, REMOVAL (Specify)</p> <p><u>Burial</u></p>	
<p>23b. DATE</p> <p><u>12-16-63</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY</p> <p><u>Oak Hill Cemetery</u></p>	
<p>23d. LOCATION (City, town, or county) (State)</p> <p><u>Maryville, Mo.</u></p>		<p>24. FUNERAL DIRECTOR ADDRESS</p> <p><u>Bartholomew Mortuary, Rock Port.</u></p>	
<p>25. DATE RECD. BY LOCAL REG.</p> <p><u>Dec. 17, 1963</u></p>		<p>26. REGISTRAR'S SIGNATURE</p> <p><u>Merwin J. Schaefer</u></p>	

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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 Gerty Barshatova

Licensed Embalmer No. 3173

P. O. Address Rock Pt. Md.

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.