

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *108*

Registrar's No. *108*

Registration District No. *200*

Primary Registration District No. *2725*

1. PLACE OF DEATH:

(a) County *Macon*
 (b) City or town *Still-Hildreth Sanatorium*
 (c) Name of hospital or institution: *Still-Hildreth Sanatorium*
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution *3 mos. 3 days*
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Missouri* (b) County *Adair*
 (c) City or town *Rural*
 (If outside city or town limits, write "RURAL")
 (d) Street No. *West of Kirksville, Mo.*
 (If rural, give location)
 (e) Citizen of foreign country? *No* (Yes or No)
 If yes, name country *1*

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *October* day *16*
 year *1944* hour *5* minute *30* P.M.
 21. I hereby certify that I attended the deceased from *July 13*, 19*44*, to *October 16*, 19*44*
 that I last saw him alive on *October 16*, 19*44*,
 and that death occurred on the date and hour stated above.

Immediate cause of death *BRAIN Tumor of Left Frontal Lobe (unspecified)*

Due to *57d*

Other conditions (Include pregnancy within 3 months of death)

Major findings:
 Of operations
 Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify)
 (b) Date of occurrence
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
 While at work? (Specify type of place) (e) Means of injury *2*

23. Signature *Robert Black Cross* (M.D. or other) *D.O.*
 Address *S.H.O. 3, Macon, Mo.* Date signed *Oct 16, 1944*

3. (a) PRINT FULL NAME *Charles Henry Neadermiller*

3. (b) If veteran, name war
 3. (c) Social Security No.

4. Sex *male* 0 5. Color or race *white* 0 6. (a) Single, widowed, married, divorced *single*

6. (b) Name of husband or wife
 6. (c) Age of husband or wife if alive years

7. Birth date of deceased *March 1 1876*
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<i>68</i>	<i>7</i>	<i>14</i>	hr. min.

9. Birthplace *Missouri*
 (City, town, or county) (State or foreign country)

10. Usual occupation *Farming*

11. Industry or business

12. Name *George Neadermiller*

13. Birthplace *Germany*
 (City, town, or county) (State or foreign country)

14. Maiden name *Louise Dentler*

15. Birthplace *St. Louis Missouri*
 (City, town, or county) (State or foreign country)

16. (a) Informant *Thomas Neadermiller*

(b) Address *Yarrow, Missouri*

17. (a) *Burial* (Burial, cremation, or removal) (b) Date thereof *Oct 18 1944*
 (Month) (Day) (Year)

(c) Place: burial or cremation *Mt. Carmel*

18. (a) Signature of funeral director *W.A. McCallum*

(b) Address *South Gifford, Missouri*

19. (a) *11/3/44* (Date received local registrar) (b) *Travis B. Hunkler* (Registrar signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED *NOV 14 1944*

RECEIVED

District Health Officer No. 10

District File Number 11-44-1982

Date Filed NOV 10 1944

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.....

....., Registered Apprentice No.

working under my personal supervision.

W. H. McCollum

Signed

W. H. McCollum

Licensed Embalmer No. 2052

P. O. Address South Gifford, 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 this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 14 1944

State File No. _____

Registration District No. 200

Primary Registration District No. 5725

Registrar's No. 108

1. PLACE OF DEATH:

(a) County Mason
(b) City or town Studson Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Charles H. Neadermiller

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Mar 1 1878
(Month) (Day) (Year)

8. AGE: Years 68 Months 7 Days no If less than one day _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Yvra B. Hunkler
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct Day 16 Year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____
that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

34710