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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED NOV 19 1947

Registration District No. 1743

Primary Registration District No. 4193

Registrar's No. 24

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

1. PLACE OF DEATH:
 (a) County Gasconade
 (b) City or town Hermann
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Workman Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 weeks
(Specify whether years, months or days)
 In this community 2 years

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Gasconade 37
 (c) City or town "Rural"
(If outside city or town limits, write "RURAL")
 (d) Street No. 9 mi. S. W. of Hermann
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME HELEN ELLA NEFF
 (b) If veteran, name war ----
 (c) Social Security No. None

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 (b) Name of husband or wife John Neff
 (c) Age of husband or wife if alive 64 years
 7. Birth date of deceased June 12 1881
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>66</u>	<u>4</u>	<u>16</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

MOYER FATHER {
 12. Name Albert Matejka
 13. Birthplace Portland Mo
(City, town, or county) (State or foreign country)
 14. Maiden name Adeline Kooney
 15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant John Neff,
 (b) Address Hermann, Mo
 17. (a) Removal (b) Date thereof 10-29-47
(Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director Hugost Poljauer
 (b) Address Hermann, Mo

19. (a) 10/29/47 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month October day 28
 year 1947 hour 5 minute _____ P. M.
 21. I hereby certify that I attended the deceased from October 12
1947 to October 28 1947;
 that I last saw her alive on October 28 1947;
 and that death occurred on the date and hour stated above.
 Immediate cause of death Atelectasis +
Cardiac failure
 Duration 16 days
 Due to Fracture of hip 16 days
Rheumatic heart disease. years
 Due to Trauma
 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) Accident
 (b) Date of occurrence October 12, 1947 37
 (c) Where did injury occur? Gasconade
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public place - while fishing.
(Specify type of place)
 While at work? _____ (e) Means of injury Fall
 23. Signature Carol T. Spear M.D. (M. D. or other) C
 Address Hermann, Mo Date signed 10-29-47

Date Filed NOV 18 1947
District File Number

District Health Officer No. 9

RECEIVED

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.

Signed.....

Hugost Blumer

Licensed Embalmer No. 3160

P. O. Address Hermann, 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.