

FILED JAN 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Reidinger

State File No. 537

220

BIRTH NO.		REG. DIST. NO. 69	PRIMARY REG. DIST. NO. 4121	Registrar's No. 4	
1. PLACE OF DEATH a. COUNTY Christian		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Christian			
b. CITY (If outside corporate limits, write RURAL and give town) Billings		c. LENGTH OF STAY (in this place) 67 Yrs		c. CITY (If outside corporate limits, write RURAL and give township) Billings	
d. FULL NAME OF HOSPITAL OR INSTITUTION X		d. STREET ADDRESS (If rural, give location) X			
3. NAME OF DECEASED (Type or Print) a. (First) Mary		b. (Middle) T.		c. (Last) Neyer	
4. DATE OF DEATH Jan. 10, 1950		5. SEX Female			
6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Nov. 4 1876	
9. AGE (In years last birthday) 73		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Ferdinand, Indiana		12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME J.B. Berghaus		13b. MOTHER'S MAIDEN NAME Theresa Auffert		14. NAME OF HUSBAND OR WIFE C.A. Neyer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME ADDRESS C.A. Neyer, Billings, Mo.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, assthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary sclerosis DUE TO (c) Generalized arteriosclerosis 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH 5 minutes
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR	
22. I hereby certify that I attended the deceased from July 19 49, to January 1950; that I last saw the deceased alive on January 9, 1950, and that death occurred at 10a m., from the causes and on the date stated above.					
23a. SIGNATURE Karl I. Leidinger Jr. M.D.		23b. ADDRESS Billings, Mo.		23c. DATE SIGNED Jan 12, 1950	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1/12/50		24c. NAME OF CEMETERY OR CREMATORY St. Joseph Cemetery	
24d. LOCATION (City, town, or county) Billings, Mo.		24e. (State)			
DATE REC'D BY LOCAL REG. 1-12-1950		REGISTRAR'S SIGNATURE Allene Brewer		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H.H. Lohmeyer Springfield, Mo.	

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

RECEIVED JAN 17 1950

District Health Office No. 6,

District File Number 150-89

Date Filed : DEC 19-50

9

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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.

Signed.....

Walter E. Hamilton

Signed.....

Student Embalmer

Licensed Embalmer No. 3808

P. O. Address Springfield, 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.