

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

21852

FILED JUN 17 1950

State File No. 4981

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY OR TOWN <b>St. Louis, Mo.</b>		c. LENGTH OF STAY (In this place) <b>3-27-50</b>		c. CITY OR TOWN <b>St. Louis</b>		2139	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Infirmiry Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>13 5600 Arsenal</b>			
3. NAME OF DECEASED (Type or Print) <b>JAMES</b>		a. (First) _____		b. (Middle) <b>N.</b>		c. (Last) <b>NEISZ</b>	
4. DATE OF DEATH <b>May 29 1950</b>		(Month) _____ (Day) _____ (Year) _____		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Mar Widowed</b>		8. DATE OF BIRTH <b>June 6, 1860</b>		9. AGE (In years last birthday) <b>89</b>		IF UNDER 1 YEAR Months <b>11</b> Days <b>22</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <b>Unknown</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Pheebe R. Neisz</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Nancy Woodie Clayton</b> ADDRESS <b>I819 Longfellow</b>			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Uremia Terminal</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Renal Calculus</b> DUE TO (c) <b>Carcinoma of Prostate</b>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) _____ (m.) _____		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>177X</b>			
22. I hereby certify that I attended the deceased from <b>July 8 1948</b> to <b>May 29 1950</b> , that I last saw the deceased alive on <b>May 29 1950</b> , and that death occurred at <b>10:50 P.M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Clotus L. Krog, M.D.</b> (Degree or title) _____				23b. ADDRESS <b>5600 Arsenal, St. Louis</b>		23c. DATE SIGNED <b>June 1950</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>June 7, 1950</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Cemetery</b>		24d. LOCATION (City, town, or county) <b>Lemay Ferry Road</b> (State) _____	
DATE REC'D BY LOCAL REG. <b>JUN 6 1950</b>		REGISTRAR'S SIGNATURE _____		25. FUNERAL DIRECTOR'S SIGNATURE <b>C. Hoffmeister</b> ADDRESS <b>U&amp;L Co. 7814 S. Broadway</b>			

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

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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed *Linn C. Hoffmann*

Signed.....  
Student Embalmer

Licensed Embalmer No. *3871*

P. O. Address *7814 S. Broadway*

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.