

FILED MAY 14 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3288  
State File No. 11631

117  
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BIRTH NO. _____		REG. DIST. NO. 42		PRIMARY REG. DIST. NO. 1000		Registrar's No. 499		
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u>				
b. CITY (If outside corporate limits, write RURAL and give township) <u>St Joseph</u>		c. LENGTH OF STAY (in this place) <u>334 1/2 hrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City Mo</u>		d. STREET ADDRESS (If rural, give location) <u>125 West 14th Kansas City</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State State Hospital # 2</u>								
3. NAME OF DECEASED a. (First) <u>Anna</u> b. (Middle) _____ c. (Last) <u>Neller</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>5 6 1951</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 30, 1871</u>	9. AGE (in years) (last birthday) <u>79 yrs</u>		IF UNDER 24 HRS. Hours   Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife at home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>		
13a. FATHER'S NAME <u>William H. Jennings</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Ann Gilliland</u>		14. NAME OF HUSBAND OR WIFE <u>Charles Miller</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mr. J. K. Jennings 921 Prospect,</u>				
						St. Joseph 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cran hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS* Conditions contributing to the death but not related to the disease or condition causing death: <u>Psychotic</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Suddenly</u>  <u>20 yrs</u>  <u>33 yrs</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		331 X		20. AUTOPSY? YES <input 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) (Min.)		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 <u>Jan 1st, 1951</u> to <u>5-6</u> , 1951, that I last saw the deceased alive on <u>5-5</u> , 1951, and that death occurred at <u>5a m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>Louis M.D. State Hospital # 2</u>				23b. ADDRESS		23c. DATE SIGNED <u>5-6-1951</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>5/8/51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Cosby Missouri</u>		
DATE REC'D BY LOCAL REG. <u>May 10, 1951</u>		REGISTRAR'S SIGNATURE <u>Carl C. Casper</u>		440		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Newman Funeral Home</u>		
						ADDRESS <u>St. Joseph Mo.</u>		

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

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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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....  
Student Embalmer

Signed.....

*James B. Hawkins*

Licensed Embalmer No. 4586

P. O. Address 319 S 10th St. - Jena

**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.