No. 300
10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27554

FILED SEP 8 - 1952

BIRTH NO. _____ REG. DIST. NO. 82 PRIMARY REG. DIST. NO. 3017 Registrar's No. 87

1. PLACE OF DEATH
a. COUNTY: Cooper
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boonville
c. LENGTH OF STAY (in this place): 1 mo
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution give street address or location): St Joseph Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Cooper
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pilot Grove Mo
d. STREET ADDRESS (or rural give location): College Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): KATHRYN
b. (Middle): —
c. (Last): NECKERMAN

4. DATE OF DEATH (Month) (Day) (Year): Aug-29-1952

5. SEX: Fem
6. COLOR OR RACE: W.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Feb 17-1876
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Tipton Mo
12. CITIZEN OF WHAT COUNTRY?: USA.
13a. FATHER'S NAME: Peter Thiel
13b. MOTHER'S MAIDEN NAME: Kathryn Bestgen
14. NAME OF HUSBAND OR WIFE: None
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: No
17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS: Edw. Thiel Tipton 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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Hypertension, arteriosclerosis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: 331X
20. AUTOPSY? YES ☐ NO ☒

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 WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 20 June, 1952, *to* 29 Aug, 1952, *that I last saw the deceased alive on* 29 Aug, 1952, *and that death occurred at* 2 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Wm Lane D MD
23b. ADDRESS: Boonville, Mo
23c. DATE SIGNED: 8/30/52

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept-1-1952
24c. NAME OF CEMETERY OR CREMATORY: St Joseph
24d. LOCATION (City, town, or county) (State): Pilot Grove Mo

DATE REC'D BY LOCAL REG.: 8-31-52
REGISTRAR'S SIGNATURE: D E Hooper 381
25. FUNERAL DIRECTOR'S SIGNATURE: Hayes & Painter
ADDRESS: Pilot Grove Mo

(Licensed Embalmer's Statement on Reverse Side)

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

OCT 5 1952

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.

Student .....
Student Embalmer

Signed Peyton E Hayes

Licensed Embalmer No. 3074

P. O. Address Pilot Grove M

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.