

FILED JUN 9 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 17430

REG. DIST. NO. 75 PRIMARY REG. DIST. NO. 3015 Registrar's No. 48

0251  
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY <u>Clinton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clinton</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Cameron</u>		c. LENGTH OF STAY (If this place) <u>80 yrs</u>	
c. CITY (If outside corporate limits, write RURAL and give township) <u>Cameron</u>		d. STREET ADDRESS (If rural, give location) <u>112 1/2 E. Third St.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>112 1/2 E. Third St.</u>		d. STREET ADDRESS (If rural, give location) <u>112 1/2 E. 3rd.</u>	
3. NAME OF DECEASED a. (First) <u>William</u> b. (Middle) <u>Edward</u> c. (Last) <u>Neff</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>June-3-1953</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>July 16 1872</u>
9. AGE (Years) (Months) (Days) <u>80</u>		10. MARRIAGE HISTORY IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Painting</u>	
11. BIRTHPLACE (City and State or Foreign Country) <u>Clinton Co. Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>Peter Neff</u>		13b. MOTHER'S MAIDEN NAME <u>Frances Major</u>	
14. NAME OF HUSBAND OR WIFE <u>Mary Etta Neff</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>No</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Joy Doyle</u>		18. ADDRESS <u>Vinton Iowa</u>	
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>Cerebral Hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>331x</u>	
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) (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>6-3</u> 19 <u>53</u> , to <u>6-3</u> 19 <u>53</u> that I last saw the deceased alive on <u>19</u> and that death occurred at <u>9:30 a.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>J. D. Kenies, MD</u> (Degree or title)		23b. ADDRESS <u>Cameron Mo</u>	
23c. DATE SIGNED <u>6-3-53</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>6-5-1953</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Graceland Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Cameron, Mo</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. W. Moser</u>		25. ADDRESS <u>De Moss CRUNK Cameron, Mo</u>	
DATE REC'D BY LOCAL REG. <u>6-3-53</u>			

**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 *James G. Gunk* \_\_\_\_\_

Licensed Embalmer No. *2533* \_\_\_\_\_

P. O. Address *Cameron 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.