

FILED APR 19 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **12604**BIRTH NO. _____ REG. DIST. NO. **385** PRIMARY REG. DIST. NO. **3099** Registrar's No. **20**

1. PLACE OF DEATH a. COUNTY Linn		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo Linn COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marceline, Mo		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marceline	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Francis Hospital		d. STREET ADDRESS (If rural, give location) 058/0	

3. NAME OF DECEASED (Type or Print) a. (First) JOHN	b. (Middle) LEONARD	c. (Last) McNEECE	4. DATE OF DEATH (Month) (Day) (Year) 4 4 54
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5. SEX M	6. COLOR OR RACE O W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M	8. DATE OF BIRTH 5/21/54	9. AGE (In years last birthday) 75	# UNDER 1 YEAR Months 10 Days 13	# UNDER 24 HRS. Hours 3 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Coffeerville, Kans.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Thomas McNeece	13b. MOTHER'S MAIDEN NAME Nancy Bright	14. NAME OF HUSBAND OR WIFE Aloma McNeece
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 709-14-2987	17. INFORMANT'S SIGNATURE OR NAME Mrs Aloma McNeece	ADDRESS Marceline, Mo
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombotic infarction		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive & transcerebral DUE TO (c) Heart Disease		
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	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **1952** to **4-4**, 19**54**, that I last saw the deceased alive on **4-4**, 19**54**, and that death occurred at **3:00** p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Robert H. Smith M.D.	23b. ADDRESS Marceline, Mo 4654	23c. DATE SIGNED 4-6-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) B	24b. DATE 4/7/54	24c. NAME OF CEMETERY OR CREMATORY Rose Hill	24d. LOCATION (City, town, or county) (State) Brookfield Mo
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DATE REC'D BY LOCAL REG. 45-6-54	REGISTRAR'S SIGNATURE Mary Jane Ridgway	401-0	25. FUNERAL DIRECTOR'S SIGNATURE James M. Laughlin	ADDRESS Marceline
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10. 48

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APR 20

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
Student Embalmer

Student Embalmer No.

Signed *George D. Raymond*
Licensed Embalmer No. *4425*

P. O. Address *Nashville, 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.