

THE DIVISION OF HEALTH OF MISSOURI

FILED FEB 27 1956

STANDARD CERTIFICATE OF DEATH

State File No. **6988**
Registrar's No. **415**

BIRTH NO. **10660-56** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. LENGTH OF STAY (in this place) 4/81	c. CITY OR TOWN Berkeley
d. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital		STREET ADDRESS (If rural, give location) 6030 Washington Ave. 21	

3. NAME OF DECEASED (Type or Print) a. (First) Mary	b. (Middle) Jean	c. (Last) Neagles	4. DATE OF DEATH (Month) (Day) (Year) 1 12 56
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 1-7-56
9. AGE (in years last birthday) 5	IF UNDER 1 YEAR Months 1	IF UNDER 24 HRS. Days 47	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10a. USUAL OCCUPATION	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Allen LeRoy Neagles	13b. MOTHER'S MAIDEN NAME Lorraine Spellmeyer	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Allen L. Neagles	ADDRESS 6030 Washington
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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, asthenia, 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) Spina Bifida		
ANTECEDENT CAUSES		DUE TO (b)	
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hydrocephalus			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 751x	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	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 1/7, 1956, to 1/12, 1956, that I last saw the deceased alive on 1/12, 1956, and that death occurred at 3:05 P.m., from the causes and on the date stated above.

23a. SIGNATURE Thugh R. Smith	(Degree or title) M.D.	23b. ADDRESS 607 N. Grand	23c. DATE SIGNED 1-13-56
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan. 13, 1956	24c. NAME OF CEMETERY OR CREMATORY Bethlehem Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County
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DATE REC'D BY LOCAL REG. JAN 13 1956	REGISTRAR'S SIGNATURE Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE BEIDERWIEDEN F.H. INC.	ADDRESS 1936 St. Louis Ave
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(Licensed Embalmer's Statement on Reverse Side)

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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

W. E. Miller
Licensed Embalmer No.
P. O. Address

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.