

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10882

FILED APR 2 - 1956

State File No.

BIRTH NO. REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2998**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY	
b. CITY (If outside corporate limits, write RURAL, and give township) OR St. Louis TOWN		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (in this place)		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4726 Olive St.		e. STREET ADDRESS (If rural, give location) 124727 Olive 2129	

3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) Neeladay c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) 3 21 56		
5. SEX F		6. COLOR OR RACE Col		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	
8. DATE OF BIRTH July 24, 1888		9. AGE (In years last birthday) 67		10. IF UNDER 1 YEAR Months 7 Days 27	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Miss.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME John Davis Penn		13b. MOTHER'S MAIDEN NAME Alice Herman	
14. NAME OF HUSBAND OR WIFE Jamie		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. ?	

17. INFORMANT'S SIGNATURE OR NAME Jamie Neeladay		ADDRESS 4726 Olive	
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocarditis, Chronic		INTERVAL BETWEEN ONSET AND DEATH several weeks	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b)			
		DUE TO (c)			
11. 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"/>	
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)		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 **Oct 15, 1955** to **Mar 21, 1956** that I last saw the deceased alive on **Mar 20, 1956**, and that death occurred at **3:30 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Clyde B. Kane M.D.		23b. ADDRESS 206 Walton		23c. DATE SIGNED 3-23-56	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3-24-56		24c. NAME OF CEMETERY OR CREMATORY Brunwood		24d. LOCATION (City, town, or county) (State) St. Louis	
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DATE REC'D BY LOCAL REG. MAR 24 1956		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE E. B. Hoove		ADDRESS 1221 N. Grand	
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E.P. (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 *Melvin Blackman*.....

Licensed Embalmer No. *39*.....

P. O. Address *1221st*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.