

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-032836

STATE FILE NUMBER

FILED SEP 24 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4212

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Nodaway		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Maryville		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Marys Hospital		Length of stay in lb 24 Days	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First REV. AUGUSTINE Middle MCNEILL Last MCNEILL			4. DATE OF DEATH Sept. 2, 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7, 1984	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10b. KIND OF BUSINESS OR INDUSTRY Catholic		11. BIRTHPLACE (City and state or country) Moberly, Mo.	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Wm D. McNeill		13b. MOTHER'S MAIDEN NAME Jane McPhee	
14. NAME OF HUSBAND OR WIFE None		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW # 1		16. SOCIAL SECURITY NO. None	
17. INFORMANT Joseph McNeill		Address St. Joseph, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure					INTERVAL BETWEEN ONSET AND DEATH 20 min
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. } DUE TO (b) Acute Brain Syndrome					20 min
DUE TO (c) Post electroshock treatment					21 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) agitated depression					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 8/20/58 to 9/2/58 and last saw ^{her} him alive on 9/2/58 Death occurred at 9:15 A m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) John D. De Mottr M.D.			22b. ADDRESS 1440 Professional Bldg		22c. DATE SIGNED 9/3/58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Sept. 2, 58	23c. NAME OF CEMETERY OR CREMATORY Int. Olivet		23d. LOCATION (City, town, or county) (State) St. Joseph, Mo.
24. FUNERAL DIRECTOR Werman W. DeLiefden		ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. 9-3-58	26. REGISTRAR'S SIGNATURE Alva Minshall

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

John D. De Mottr

12

JAN 5 1959

W 2-5492

4:30

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 _____

Robert H. Gash

Licensed Embalmer No. 3308

P. O. Address. M. Joseph, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

also 1/11/59
1440 1/11/59
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