Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-004501
STATE FILE NUMBER

FILED MAR 2 1959 Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 96

1. PLACE OF DEATH
a. COUNTY Boone
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Columbia — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Univ. Medical Center — Length of stay in 1b: 2 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Pemiscot
c. CITY OR TOWN Cottonwood — Inside Limits Yes [ ] No [ ]
d. STREET ADDRESS (If outside, give location) County Farm — Reside on Farm Yes [X] No [ ]

3. NAME OF DECEASED (Type or print): First James Middle Edward Last Neely

4. DATE OF DEATH Month Feb Day 21 Year 1959

5. SEX Male

6. COLOR OR RACE White

7. MARRIED [ ] **NEVER MARRIED** [X] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH ?? 1888

9. AGE (In years last birthday) 71 — IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) Curran, Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME J. M. Neely

13b. MOTHER'S MAIDEN NAME Unknown

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Hospital Records Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ASPHYXIATION — INTERVAL BETWEEN ONSET AND DEATH: ???
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) ASPIRATION OF VOMITUS — ???
DUE TO (c) CHRONIC BRAIN SYNDROME ASSOCIATED WITH MENINGOENCEPHALITIC SYPHILIS — OVER 21 YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
1. Fracture, neck of Rt. Femur 2. Surgical Arthroplasty, Rt. Hip 20 Feb 59

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [X] **SUICIDE** [ ] **HOMICIDE** [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Fell in State Hosp. #4, Farmington, Mo. Details of how fall happened not known.

20c. TIME OF INJURY Hour ?? a.m. p.m. Month, Day, Year Feb. 15, 1959

20d. INJURY OCCURRED WHILE AT WORK [ ] **NOT WHILE AT WORK** [X]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) MENTAL HOSPITAL

20f. CITY, TOWN, OR LOCATION FARMINGTON **COUNTY** **STATE** Mo.

21. I attended the deceased from 19 FEB. 1959, to 21 FEB. 1959 and last saw her/him alive on 21 FEB. '59
Death occurred at 10:36 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE John P. Palmer, M.D. (Degree or title)

22b. ADDRESS University of Missouri Med. Center Columbia, Mo.

22c. DATE SIGNED 21 Feb 59

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE Feb. 25, 1959

23c. NAME OF CEMETERY OR CREMATORY Unv. of Mo. Medical

23d. LOCATION (City, town, or county) Center, Columbia, Mo. (State)

24. FUNERAL DIRECTOR M. D. Overholser, M. D. **ADDRESS** Dept. of Anatomy U of Mo

(Licensed Embalmer's Statement on Reverse Side)

25. DATE RECD. BY LOCAL REG. Feb 26 1959

26. REGISTRAR'S SIGNATURE Mrs R. E. Palmer

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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 ..... Signed .....
Signature of Student Embalmer

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.