

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020150
STATE FILE NUMBER

JUN 8 1959 Registration District No. 381 Primary Registration District No. 4515 Registrar's No. 48

300
1-57

1. PLACE OF DEATH a. COUNTY Sullivan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Sullivan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Milan		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Pollock
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Sullivan Co. Memorial Hosp.		Length of stay in 1b 2 Da	d. STREET (If outside, give location) ADDRESS No street address
3. NAME OF DECEASED (Type or print) First Middle Last Chester Vane Neighbors			4. DATE OF DEATH Month Day Year May 30, 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7, 1895
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mgr. Credit Union		9b. KIND OF BUSINESS OR INDUSTRY Banking	9. AGE (In years last birthday) 63 IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
11a. FATHER'S NAME William Henry Neighbors		11b. MOTHER'S MAIDEN NAME Alice Magdalene Gilbert	11. BIRTHPLACE (City and state or country) Pollock, Missouri
12a. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) Yes World War I		12b. SOCIAL SECURITY NO. None	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME William Henry Neighbors		13b. MOTHER'S MAIDEN NAME Alice Magdalene Gilbert	
14a. NAME OF HUSBAND OR WIFE Vivienne Alice Neighbors		17. INFORMANT Charles H. Neighbors, Milan, Mo. 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) Left Sided Heart Failure DUE TO (b) Right Sided Heart Failure & Asthma DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs 10 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 WORK <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 Pollock COUNTY Sullivan STATE Mo	
21. I attended the deceased from May 28, 1959, to May 30, 1959 and last saw her alive on Aug 30, 1959 Death occurred at 10:01 PM on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Joseph S. Kungwe (Degree or title) M.D.		22b. ADDRESS Milan, Mo	22c. DATE SIGNED 6/4/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 3, 1959	23c. NAME OF CEMETERY OR CREMATORY Scobee Cemetery	23d. LOCATION (City, town, or county) Pollock, Mo. (State)
24. FUNERAL DIRECTOR Glenn E. Kuntzow, Green City, Mo. 6-4-59		25. DATE RECD. BY LOCAL REG. 6-4-59	26. REGISTRAR'S SIGNATURE Mrs. M. W. Beckett

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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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 *Karl P. Kent*

Licensed Embalmer No. *4689*

P. O. Address *Green City, 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.