

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027873

FILED VS AUG 4 1959

Registration District No. 352 Primary Registration District No. _____ Registrar's No. 79

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Taney</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Miller</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Forsyth</u>		Length of stay in 1b <u>1</u> year		c. CITY OR TOWN <u>Eldon</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lake View Rest Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>105 South Walnut</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Kathryn</u> Middle <u>J.</u> Last <u>Neville</u>				4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>1-10-1887</u>	9. AGE (last birthday) <u>72</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>		11. BIRTHPLACE (City and state or country) <u>Guston, Kentucky</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Unknown Smith</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>James Neville, deceased</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. E. C. Olson, Eldon, Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Hydrostatic Pneumonia</u>							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Senile Dementia</u>							
DUE TO (c) <u>Stroke - Arterial Hypertension</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes, <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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 _____ a.m. _____ p.m. Month, Day, Year _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <u>6-12-59</u> to <u>7-13-59</u> and last saw ^{her} _{him} alive on <u>7-13-59</u> Death occurred at <u>4:30 P.M.</u> on <u>7-13-59</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Mary King, D.O.</u>				22b. ADDRESS <u>Forsyth, Mo.</u>		22c. DATE SIGNED <u>7-26-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>7-14-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Eldon Cemetery</u>		23d. LOCATION (City, town, or county) <u>Eldon, Mo</u>		(State)	
24. FUNERAL DIRECTOR <u>Wheeler Chapel</u>		ADDRESS <u>Branon Mo</u>		25. DATE RECD. BY LOCAL REG. <u>7-31-59</u>	26. REGISTRAR'S SIGNATURE <u>Heber Campbell</u>		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____

Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Walter S. Gobb

Licensed Embalmer No. 473

P. O. Address Travis

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.