

I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-014747

ED VS APR 18 1960

STATE FILE NUMBER

Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 78

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Gasconade</u>						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington</u>		Length of stay in 1b <u>1-week</u>		c. CITY OR TOWN <u>BLAND</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>St. Francis Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		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 <u>HERMAN</u> Middle <u>D.</u> Last <u>Neese</u>				4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1960</u>						
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>April 7-1892</u>	9. AGE (last birthday) <u>67</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier - Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>BANK - own farm</u>	11. BIRTHPLACE (City and state or country) <u>Gasconade County - MO</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Herman Neese</u>			13b. MOTHER'S MAIDEN NAME <u>Minnie Sandwehr</u>			14. NAME OF HUSBAND OR WIFE <u>deceased</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>NWT</u>		16. SOCIAL SECURITY NO. <u>488-38-0871</u>		17. INFORMANT <u>HERMAN C. NEESE</u> Address <u>BLAND MO</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u>								INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>chronic arteriosclerotic hypertension myocarditis</u>								
		DUE TO (c) <u>Diabetes Mellitus</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 <u> </u> a.m. <u> </u> p.m. <u> </u>	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>March 30/60</u> to <u>April 6/60</u> and last saw ^{from} him alive on <u>April 6, 60</u> Death occurred at <u>3:30</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title) <u>[Signature]</u>				22b. ADDRESS <u>M 15 Washington MO</u>			22c. DATE SIGNED <u>4/9/60</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>April 9/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Owensville - Mo.</u>					
24. FUNERAL DIRECTOR <u>Chetan Dossman</u>		25. DATE RECD. BY LOCAL REG. <u>4/11/60</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>						

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

APR 19 1968

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____

or by _____, _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Chester Lassman

Licensed Embalmer No. 4178

P. O. Address Bland - Va

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