

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 12 1960 318

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-60-024806

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **6237** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri. Length of stay in 1b 3 years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY _____ c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 1218 Carr Street., Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Enroute Homer G. Sp Phillips Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1218 Carr Street., Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED Hospital (Type or print) Rose Lee Neal	4. DATE OF DEATH Month June Day 16 Year 1960
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5. SEX Female	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/31/1939	9. AGE (last birthday) 20	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Blytheville, Arkansas	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME George Neal	13b. MOTHER'S MAIDEN NAME Gladys Davis	14. NAME OF HUSBAND OR WIFE Nil
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address George Neal, 1026 Denny, Blytheville, Ark.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Traumatic Internal Hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. Incised wounds of neck severing major vessels. DUE TO (b) _____ DUE TO (c) _____	INTERVAL BETWEEN ONSET AND DEATH 982+
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PART II. OTHER SIGNIFICANT CONDITIONS (Contributing to death but not related to the terminal disease condition given in PART I (a)) stabbed with knife in hands of neck	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
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19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) found lying back on front of about 1320 Union Ave. about 6:40 pm., June 16th 1960
20c. TIME OF INJURY Hour 6:40 Month, Day, Year 6/16/60	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.) Street 20f. CITY, TOWN, OR LOCATION St Louis Mo COUNTY STATE

21. I attended the deceased from _____ to _____ and last saw her alive on _____
 Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>[Signature]</i>	22b. ADDRESS 1300 [Address]	22c. DATE SIGNED 6-18-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6/18/60	23c. NAME OF CEMETERY OR CREMATORY Caril's Chapel Cemetery	23d. LOCATION (City, town, or county) (State) Armour, Arkansas.
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24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, Inc., 4700 Washington Blvd.,	25. DATE RECD. BY LOCAL REG. JUN 18 1960	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS JUL 1 8 1960
MS JUL 1 2 1960

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 *Thomas R. Jader*

Licensed Embalmer No. 4077

P. O. Address St. Louis

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