

**FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS AUG 29 1960

**=60=029537**

STATE FILE NUMBER

Registration District No. **38** Primary Registration District No. **3006** Registrar's No. **471**

|  |  |   |  |   |  |  |   |  |  |   |  |                              |  |
|--|--|---|--|---|--|--|---|--|--|---|--|------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Boone</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo</b> b. COUNTY <b>Callaway</b>                       |  |  |   |  |  |   |  |                              |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Columbia</b>   |  | Length of stay in lb<br><b>1mo. 10dys</b>   |  | c. CITY OR TOWN <b>New Bloomfield</b>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |  |  |   |  |                              |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>University of Mo. Medical Center</b>   |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   | d. STREET ADDRESS (If outside, give location)<br><b>None given</b> |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |  |   |  |                              |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>James</b> Middle <b>Ralph</b> Last <b>Neal</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>22</b> Year <b>1960</b>  |  |  |   |  |  |   |  |                              |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>8-15-99</b>   |   | 9. AGE (last birthday)<br><b>61</b>  |  | IF UNDER 1 YEAR<br>Months Days                                    |  | IF UNDER 24 HR<br>Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Unknown</b>   |  | 11. BIRTHPLACE (City and state or country)<br><b>Callaway Co. Mo</b>                 |   | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S. of Am.</b>  |  |   |  |                              |  |
| 13a. FATHER'S NAME<br><b>John Neal</b>   |  |   |  | 13b. MOTHER'S MAIDEN NAME<br><b>Mary Taylor</b>   |  |  |   | 14. NAME OF HUSBAND OR WIFE<br><b>Unknown</b>  |  |   |  |                              |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT<br><b>Medical Records</b>  |   | Address <b>University Hoop. Columbia Mo.</b>   |  |   |  |                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Liver Failure</b><br>DUE TO (b) <b>Primary Hypertension</b><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  |   |  |   |  |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 days</b><br><b>3 mo.</b> |  |                              |  |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |   |  |                              |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input 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<br>Hour a.m. p.m.<br>Month, Day, Year  |  |   |  |   |  |  |   |  |  |   |  |                              |  |
| 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   |  | COUNTY  |  | STATE                        |  |
| 21. I attended the deceased from <b>7-12-60</b> to <b>8-22-60</b> and last saw him alive on <b>8-22-60</b><br>Death occurred at <b>8:59pm</b> m on the date stated above, and to the best of my knowledge, from the causes stated.   |  |   |  |   |  |  |   |  |  |   |  |                              |  |
| 22a. SIGNATURE (Degree or title)<br><b>Franklin L. Huntshell M.D. Univ. Mo. Med. Center</b>  |  |   |  |   |  | 22b. ADDRESS<br><b>Brumley</b>   |   |  |  | 22c. DATE SIGNED<br><b>8-25-60</b>                                |  |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>Aug 25-60</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gott. Ceme</b>   |  |  |   | 23d. LOCATION (City, town, or county)<br><b>Brumley</b>  |  | (State)<br><b>mo</b>  |  |                              |  |
| 24. FUNERAL DIRECTOR<br><b>Claypool Service New Bloomfield</b>   |  |   |  | ADDRESS   |  | 25. DATE RECD. BY LOCAL REG.<br><b>Aug 23 1960</b>                                   |   | 26. REGISTRAR'S SIGNATURE<br><b>Mrs. R.E. Palmer</b>   |  |   |  |                              |  |

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

*LeRoy Claypool*

Licensed Embalmer No. 4412

P. O. Address New Bloom

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.