

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-030015

STATE FILE NUMBER

Registration District No. 384 Primary Registration District No. 3039 Registrar's No. 44

AMENDED

LED SEP 11 1961

1. PLACE OF DEATH
 a. COUNTY LINN
 b. CITY (If outside corporate limits, give TOWNSHIP only) Marceline Length of stay in lb 1 day
 c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Francis Hosp Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE Mo b. COUNTY Macon
 c. CITY OR TOWN CALLAO Mo Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) - Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last NEVA ELEN TERRILL Hyde
 4. DATE OF DEATH Month Day Year 8-29-61

5. SEX Female 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced
 8. DATE OF BIRTH 7-26-92 9. AGE (last birthday) 69 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) retired sales lady 10b. KIND OF BUSINESS OR INDUSTRY - 11. BIRTHPLACE (City and state or country) CALLAO Mo 12. CITIZEN OF WHAT COUNTRY U.S.

13a. FATHER'S NAME John Y. Terrill 13b. MOTHER'S MAIDEN NAME Ethel M. Knowlton 14. NAME OF HUSBAND OR WIFE -

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 17. INFORMANT VERNE Hyde Address Beoich

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Acute Cerebrovascular accident probably INTERVAL BETWEEN ONSET AND DEATH 24 hrs
 DUE TO (b) Generalized arteriosclerosis undefinite
 DUE TO (c) -
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

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.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 Aug 27/61 to Aug 28/61 and last saw her alive on 10/3 A.M. on the date stated above, and to the best of my knowledge, from the causes stated. Death occurred at -

22a. SIGNATURE (Degree or title) Hannon A. Hainer, M.D. 22b. ADDRESS Marceline Mo. 22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE 8/31/61 23c. NAME OF CEMETERY OR CREMATORY LOC 457 Grove Cem 23d. LOCATION (City, town, or county) (State) CALLAO Mo

24. FUNERAL DIRECTOR W.S. Edwards ADDRESS Beoich Mo. 25. DATE RECD. BY LOCAL REG. Aug 31-61 26. REGISTRAR'S SIGNATURE Anna Watson

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

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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 H. S. Edwards

Licensed Embalmer No. 1961

P. O. Address Berwin, Md

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.