SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

TMENT OF PUBLIC HEALTH AND WELFARE

-61-036602
STATE FILE NUMBER

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 959

FILED OCT 23 1961

1. PLACE OF DEATH
a. COUNTY Greene
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield
Length of stay in 1b 43 yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Johns Hospital
Inside Limits Yes # No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri COUNTY Greene
c. CITY OR TOWN Springfield
Inside Limits Yes # No ☐
d. STREET ADDRESS (If outside, give location) 943 N. Douglas
Reside on Farm Yes ☐ No #

3. NAME OF DECEASED (Type or print) First Ida Middle Florence Last Neely
4. DATE OF DEATH Month October Day 10, Year 1961
5. SEX Female
6. COLOR OR RACE White
7. Married ☐ Never Married ☐ Widowed # Divorced ☐
8. DATE OF BIRTH 4-16-1961
9. AGE (last birthday) 85
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) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (City and state or country) Mt. Vernon, Mo.
12. CITIZEN OF WHAT COUNTRY U. S. A.
13a. FATHER'S NAME William Harvey Gibson
13b. MOTHER'S MAIDEN NAME Elizabeth Elmira Allen
14. NAME OF HUSBAND OR WIFE Frank Neely (Dec.)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Address Mrs. Ralph Rose Springfield, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral thrombosis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH 1 day
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 None to None and last saw her alive on 10 Oct 1961
Death occurred at 7:30 h. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Karl Leidinger MD.
22b. ADDRESS Republic, Mo
22c. DATE SIGNED 14 Oct 61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE Oct 13-1961
23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery
23d. LOCATION (City, town, or county) Mt. Vernon (State) Missouri

24. FUNERAL DIRECTOR ADDRESS Rex Rainey, Springfield, Mo.
25. DATE RECD. BY LOCAL REG. 10-20-61
26. REGISTRAR'S SIGNATURE Effie E. Meeler

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS:

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

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 Lex Carney

Licensed Embalmer No. 3312

P. O. Address Springfield, Mo.

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.