

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-024993

6109

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. \_\_\_\_\_

DO NOT WRITE ON THIS STUB

AMENDED

<p style="font-size: 24pt; font-weight: bold;">JUL 2 1962</p> <p><b>1. PLACE OF DEATH</b></p> <p>a. COUNTY _____</p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Missouri.</b> Length of stay in 1b _____</p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Missouri Baptist Hospital</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>		<p><b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <b>Missouri</b> b. COUNTY <b>Washington</b></p> <p>c. CITY OR TOWN <b>Sullivan, Mo.</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <b>Rural Route</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>									
<p><b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Carolyn Neff</b></p>		<p><b>4. DATE OF DEATH</b> Month Day Year <b>June 15, 1962</b></p>									
<p><b>5. SEX</b> <b>Female</b></p>	<p><b>6. COLOR OR RACE</b> <b>White</b></p>	<p><b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> Divorced <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <b>4/18/1889</b></p>	<p><b>9. AGE (last birthday)</b> <b>73</b></p>	<p><b>IF UNDER 1 YEAR</b> Months _____ Days _____</p>	<p><b>IF UNDER 24 HR</b> Hours _____ Min. _____</p>					
<p><b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife.</b></p>		<p><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Washington Co., Mo.</b></p>		<p><b>11. BIRTHPLACE</b> (City and state or country) <b>U.S.</b></p>		<p><b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.</b></p>					
<p><b>13a. FATHER'S NAME</b> <b>James Boyer</b></p>		<p><b>13b. MOTHER'S MAIDEN NAME</b> <b>Mary Studdard</b></p>		<p><b>14. NAME OF HUSBAND OR WIFE</b> <b>George Neff</b></p>		<p><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b></p>		<p><b>16. SOCIAL SECURITY NO.</b> <b>None</b></p>		<p><b>17. INFORMANT</b> Address <b>John Neff, Sullivan, Mo.</b></p>	
<p><b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <b>Cardiac Failure.</b></p> <p style="text-align: center;">DUE TO (b) <b>Probable Stroke-Adams.</b></p> <p style="text-align: center;">DUE TO (c) <b>433.0</b></p> <p style="font-size: 10pt;">Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p> <p>PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown</p>											
<p><b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>		<p><b>20a. ACCIDENT SUICIDE HOMICIDE</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>		<p><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)</p>							
<p><b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year</p>		<p><b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>		<p><b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p><b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE</p>					
<p><b>21. I attended the deceased from</b> <b>5-28-62</b> to <b>6-15-62</b> and last saw <b>per alive</b> on <b>6-15-62</b> Death occurred at <b>6:00</b> m on the date stated above, and to the best of my knowledge, from the causes stated.</p>											
<p><b>22a. SIGNATURE</b> (Degree or title) <b>D. L. Lewin, M.D.</b></p>					<p><b>22b. ADDRESS</b> <b>45-3 N. Taylor</b></p>			<p><b>22c. DATE SIGNED</b> <b>6-18-62</b></p>			
<p><b>23a. BURIAL, CREATION, REMOVAL (Specify)</b> <b>Removal</b></p>		<p><b>23b. DATE</b> <b>6-19-62</b></p>		<p><b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Odd Fellows Cemetery</b></p>		<p><b>23d. LOCATION</b> (City, town, or county) (State) <b>Sullivan Mo.</b></p>					
<p><b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Albert H. Hoppe, Inc., 4700 Washington Blvd,</b></p>					<p><b>25. DATE RECD. BY LOCAL REG.</b> <b>JUN 19 1962</b></p>		<p><b>26. REGISTRAR'S SIGNATURE</b> <b>Roan Smith, M.D.</b></p>				

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

**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 Robert M. Murray

Licensed Embalmer No. 3749

P. O. Address St Louis 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.