

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

3248

~~2077~~
~~2077~~

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 1003
City St. Louis (No. St. Lukes Hospital) St. _____ (ward)

File No. _____
Registered No. 744

2. FULL NAME DR. EUGENE JAMES NEVILLE

(a) Residence. No. 6629 Kingsbury St. 12 Ward. St. Louis Co. Mo.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Belle Malone Neville

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 15, 1866

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>63</u>	<u>4</u>	<u>6</u>		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Physician
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

FEB 1930

9. BIRTHPLACE (CITY OR TOWN) Chester
(STATE OR COUNTRY) Ill.

10. NAME OF FATHER James Neville

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Tennessee
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Jenette Adams

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Chester
(STATE OR COUNTRY) Ill.

14. INFORMANT Geo. Neville
(Address) 5916 Cates Ave

15. FILED 23 1930 W. C. Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 21, 1930 19

17. HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, that I last saw him alive on Jan 21, 1930, and that death occurred, on the date stated above, at 8:30 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma Bladder and Ureters

CONTRIBUTORY (SECONDARY) Uremia Toxemia (duration) 28 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Cytopathic Ex
(Signed) J. Hay Simpson M. D.
, 19 (Address) Union Club Bldg.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Valhalla Crematory DATE OF BURIAL Jan 23 1930

20. UNDERTAKER Alexandra and Sons ADDRESS 6175 Delmon

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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