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FILED JAN 16 1945
318

Registration District No. _____ Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis City Hospital - Max C. Starkloff
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5 **Memorial**
(Specify whether)
 In this community _____
years, months or days

3. (a) PRINT FULL NAME Walter Neville

3. (b) If veteran, name was First World War **3. (c) Social Security** No. _____

4. Sex male **5. Color or** white **6. (a) Single, widowed, married,** divorced married
race

6. (b) Name of husband or wife, Julia Neville **6. (c) Age of husband or wife if** 54 years
alive

7. Birth date of deceased, June 5, 1885.
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>59</u>	<u>6</u>	<u>28</u>	hr. min.

9. Birthplace Glouster, Kentucky
(City, town, or county) (State or foreign country)

10. Usual occupation Furniture Finisher

MOTHER, FATHER

11. Industry or business _____

12. Name Tom Neville

13. Birthplace Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Katherine Morrison

15. Birthplace Pelville, Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Ella Arconati
(b) Address 3910 Chilbrook Ave

17. (a) Burial **(b) Date thereof** Jan - 5 - 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation National Cem. Jefferson

18. (a) Signature of funeral director Chas A. Bell
(b) Address 4452 Washington St, 1945

19. (a) JAN 3 1945 **(b)** J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 1519 71-16th St
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 2nd
 year 1945 hour 6:05 minute P. M.

21. I hereby certify that I attended the deceased from 12/28/44
 _____, 19____, to 1/2/45, 19____;
 that I last saw h. im alive on 1/2/45, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Corbosis of Linger
 Duration _____

Due to _____

Due to 1/2/45

Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
 Of operations _____
 Of autopsy same

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (Specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature James J. Bond (Mr. D. or other) _____
Address 1515 Lafayette 1/2/45

While at work? (Specify type of place) (e) Means of injury _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

John Ketter

Licensed Embalmer No..... *3880*

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 this body is not embalmed, fact should be so stated above.