

21488

S. No. 300

V. 10.48

STANDARD CERTIFICATE OF DEATH

State File No.

5725

FILED JUL 15 1949

BIRTH NO.

REG. DIST. NO.

PRIMARY REG. DIST. NO.

Registrar's No.

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN *St Louis*

c. LENGTH OF STAY (in this place)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

a. STATE

b. COUNTY

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN *St Louis*d. FULL NAME OF HOSPITAL OR INSTITUTION *Homer G. Philips*

d. STREET ADDRESS (If rural, give location)

227 715 Mound

3. NAME OF DECEASED

a. (First)

b. (Middle)

c. (Last)

(Type or Print)

*JAMES**NEAL*

4. DATE OF DEATH

(Month)

(Day)

(Year)

*6**30**49*

5. SEX

6. COLOR OR RACE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

IF UNDER 1 YEAR

MONTHS

IF UNDER 24 HRS.

DAYS

HOURS

MIN.

*Male**Col.**Married**Jan 5 - 1895**54**54*

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME

13b. MOTHER'S MAIDEN NAME

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT'S SIGNATURE OR NAME

ADDRESS

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)

ANTECEDENT CAUSES

Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP)

(COUNTY)

(STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

(Year)

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at *415th.*, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)

23b. ADDRESS

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

*JUL 2 1949**JTB Swartz**AP Richardson 2625 Glasgow*

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed AD Richardson

Signed _____
Student Embalmer

Licensed Embalmer No. 2928

P. O. Address 2625 Glasgow

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.