

FILED JUL 8 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21880
State File No. 5666
Registrar's No.

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. 1003		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo.			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2169	
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Anthony Hospital				d. STREET ADDRESS (If rural, give location) 3923 Juniata St. 0			
3. NAME OF DECEASED (Type or Print) a. (First) JAMES b. (Middle) H. c. (Last) O'NEILL			4. DATE OF DEATH (Month) June (Day) 28 (Year) 1950				
5. SEX Male 0		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married /		8. DATE OF BIRTH May 23, 1878	
9. AGE (In years last birthday) 72		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Marion Co. Mo. 0	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
13a. FATHER'S NAME Charles O'Neill		13b. MOTHER'S MAIDEN NAME Elizabeth Reed		14. NAME OF HUSBAND OR WIFE Lou O'Neill			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Mrs. Herbert Schuster			
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.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Failure rt. ventricle ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pneumonitis Cholecystitis DUE TO (c) Enlarged Heart II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 2 hrs 3 wks 3 wks 2 yrs	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? H3H.3			
22. I hereby certify that I attended the deceased from June 6, 1950, to June 28, 1950, that I last saw the deceased alive on June 28, 1950, and that death occurred at 5:45 P.M., from the causes and on the date stated above.							
23a. SIGNATURE <i>Dr. Simpson M.D.</i>				23b. ADDRESS 3739 Gravois		23c. DATE SIGNED 6-29-50	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE July 1, 1950		24c. NAME OF CEMETERY OR CREMATORY Lanes Prairie, Mo.		24d. LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. JUN 29 1950		REGISTRAR'S SIGNATURE <i>J. B. Sasser</i>		25. FUNERAL DIRECTOR'S SIGNATURE Kriegshauser 4228 S. Kingshighway Bl.			

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed

Edwin A. M. Gerwitz

Signed.....
Student Embalmer

Licensed Embalmer No. 3024

P. O. Address.....

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.