

FILED OCT 23 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35472

State File No.

318

1003

Registrar's No. 8725

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____	
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (In this place) _____	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		2259
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Upon Arrival City Hospital</u>			28 STREET ADDRESS (If rural, give location) <u>Milner Hotel - 1734 Washington</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>James</u>		b. (Middle) <u>B</u>	c. (Last) <u>O'Neill</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>October 1st, 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>August 18, 1889</u>	9. AGE (In years last birthday) <u>62</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>12</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Theatrical Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	11. BIRTHPLACE (State or foreign country) <u>Carlyle Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>James B. O'Neill</u>		13b. MOTHER'S MAIDEN NAME <u>Jessie Feurer</u>		14. NAME OF HUSBAND OR WIFE <u>James B. O'Neill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>James W. O'Neill 2826 Semple</u>		
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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis</u> ANTECEDENT CAUSES <u>Chronic nephritis</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Chronic nephritis</u> Conditions contributing to the death but not related to the disease or condition causing death. INTERVAL BETWEEN ONSET AND DEATH <u>1901-1950</u> <u>unt.</u>				
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) _____		21f. HOW DID INJURY OCCUR? <u>H&I</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22. I hereby certify that I attended the deceased from <u>Sept 1-1951</u> to <u>Sept 29, 1951</u> , that I last saw the deceased alive on <u>Sept 29, 1951</u> , and that death occurred at <u>3:00</u> p.m., from the causes and on the date stated above.			
23a. SIGNATURE <u>H. Y. Moore M.D.</u> (Degree or title)		23b. ADDRESS <u>917-8018</u>	23c. DATE SIGNED <u>10-2-51</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>10-5-1951</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u>		
DATE REC'D BY LOCAL REG. <u>OCT 3 1951</u>	REGISTRAR'S SIGNATURE <u>Robert Smith M.D.</u>		25 FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Bansieck-Michaes 1431 Union Bl</u>		

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

Handwritten scribbles at the top of the page.

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 _____

Student Embalmer

Signed _____

Frank H. Pelham
2915

Licensed Embalmer No. _____

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.