

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023234

STATE FILE NUMBER 2 6039  
Registration District No. Primary Registration District No. Register No.

FILED JUL 7 1959

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|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR <b>St. Louis</b><br>TOWN              |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <b>St. Louis</b><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Deaconess Hosp.</b> |  | Length of stay in lb<br><b>5 wks</b>  | d. STREET ADDRESS (If outside, give location)<br><b>5527 Minnesota Ave.</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print)<br>First <b>Theodore</b> Middle <b>C.</b> Last <b>Neunlist-</b> |  |  | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>24</b> Year <b>1959</b> |  |  |
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| 5. SEX <b>M</b> | 6. COLOR OR RACE <b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 8, 1891</b> | 9. AGE (In years last birthday) <b>68</b> | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HRS<br>Hours Min. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Bookkeeper</b> | 11. BIRTHPLACE (City and state or country)<br><b>Mt. Olive, Ill.</b> | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |
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| 13a. FATHER'S NAME<br><b>Charles Neunlist</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Minnie Koch</b> | 14. NAME OF HUSBAND OR WIFE<br><b>Jennie Neunlist</b> |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)<br><b>Yes WW I</b> | 16. SOCIAL SECURITY NO.<br><b>329-10-7070</b> | 17. INFORMANT<br><b>Harry Neunlist</b> | Address<br><b>6043 Pernod Ave.</b> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac insufficiency</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 yr</b>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  | DUE TO (b) <b>arteriosclerotic heart disease</b> | <b>5 yrs</b>  |
|   | DUE TO (c) <b>arteriosclerosis, general</b>      | <b>10 yrs</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)                             |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |

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| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)<br><b>4200</b> |
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| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. p.m. | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION<br>COUNTY<br>STATE |
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| 21. I attended the deceased from <b>1 June 59</b> to <b>24 June 59</b> and last saw him alive on <b>24 June 59</b><br>Death occurred at <b>6:15 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE<br><b>Jack Barrow MD</b> (Degree or title) <b>D</b> | 22b. ADDRESS<br><b>110 S. Central (5)</b> | 22c. DATE SIGNED<br><b>25 June 59</b> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b> | 23b. DATE<br><b>June 27, 1959</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Paul Churchyard</b> | 23d. LOCATION (City, town, or county) (Specify)<br><b>St. Louis County, Mo.</b> |
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| 24. <b>Hoffmeister Colonial Mortuary</b><br><b>6464 Chippewa St. St. Louis, Mo.</b> | 25. DATE RECD. BY LOCAL REG.<br><b>JUN 26 '59</b> | 26. REGISTRAR'S SIGNATURE<br><b>Edward Smith, M.D.</b> |
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 .....  
Signature of Student Embalmer

Signed *John Shennel* .....  
Licensed Embalmer No. *4194* .....  
P. O. Address *St. Louis* .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.