

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046690

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11805

STATE FILE NUMBER

AMENDED

FILED DEC 27 1961

1. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY	a. STATE <u>Mo.</u>	b. COUNTY	b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>	Length of stay in 1b <u>2 Years</u>	c. CITY OR TOWN <u>St. Louis</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Anthony's Hospital</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3325 Wisconsin</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First	Middle	Last	Month	Day	Year
<u>CHARLES</u>	<u>H.</u>	<u>NEAGLES</u>	<u>12</u>	<u>16</u>	<u>61</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/9/02</u>	9. AGE (last birthday) <u>59</u>	IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>unemployed</u>	11. BIRTHPLACE (City and state or country) <u>Carlinville, Ill.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Charles Neagles</u>		13b. MOTHER'S MAIDEN NAME <u>Maude Sutton</u>		14. NAME OF HUSBAND OR WIFE <u>Sylvia</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>Unknown</u>	17. INFORMANT <u>Sylvia E. Neagles, 3325 Wisconsin</u>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) _____		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	<u>3</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>44.3x</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

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	COUNTY	STATE
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21. I attended the deceased from <u>Dec 1 - 1961</u> to <u>Dec 16 - 1961</u> and last saw her/him alive on <u>Dec 16 1961</u> Death occurred at <u>10:45 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>H.G. Moore MD</u> (Degree or title)	22b. ADDRESS <u>917-5018</u>	22c. DATE SIGNED <u>12-18-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12/19/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>
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24. FUNERAL DIRECTOR <u>McLAUGHLIN'S, 2301 Lafayette</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>DEC 19 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loard Smith. M.D.</u>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 James R. Chapman
Licensed Embalmer No. 4550
P. O. Address St. James, Va.

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.