

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-049075
STATE FILE NUMBER
62-049075

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 543 Registrar's No. 3622

FILED JAN 10 1963

1. PLACE OF DEATH a. COUNTY - St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Jennings		Length of stay in 1b 14 Years	c. CITY OR TOWN Jennings Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5514 Janet Ave.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5514 Janet Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First THOMAS Middle FRANCIS Last NEVILLE			4. DATE OF DEATH Month December Day 10 Year 1962			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/24/1883	9. AGE (last birthday) 79	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Street Car		10b. KIND OF BUSINESS OR INDUSTRY Public Service Co.		11. BIRTHPLACE (City and state or country) Des Moines, Iowa		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME John Neville		13b. MOTHER'S MAIDEN NAME Mary Carmody		14. NAME OF HUSBAND OR WIFE May Dyer Neville		

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. [REDACTED]	17. INFORMANT May Neville, 5514 Janet (20) Address
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18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Medullary Paralysis		1-2 min
DUE TO (b) Cerebral vascular hemorrhage		2-4 min
DUE TO (c) Hypertensive cardiovascular disease		years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized atherosclerosis		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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)	
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

21. I attended the deceased from **October 18 1962 to Dec 4, 1962** and last saw ^{her}him alive on **Dec 4, 1962**
Death occurred at **approx. 4:00 Dec 10, 1962** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Heard W. Schloeger D.O.	22b. ADDRESS 6433 W. Florissant St. L. 20	22c. DATE SIGNED Dec 12-12-62
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12/13/62	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Missouri
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24. FUNERAL DIRECTOR BUCHHOLZ MORTUARY, INC. - 5967 W. Florissant	25. DATE RECD. BY LOCAL REG. 12-12-62	26. REGISTRAR'S SIGNATURE John B. Murphy M.D.
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ
 USE BLACK INK OR TYPEWRITER RIBBON

VS 300 Rev. 4/59	DATE AMENDED
1 4008	
2 4008	
3 2	
4 0	
5 1	
6	
7 1	
8 2	
9 443X	
10	
11	
12 90-2	
13	

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 Ralph E. Lenders

Licensed Embalmer No. 4275

P. O. Address St. Louis Mo.

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.