

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

22391

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **11003**

City **St. Louis**

(No. **2209** **Habert**)

File No.

Registered No. **6583**

St.

Ward)

2. FULL NAME

Neil Mc. Daniels

(a) Residence. No. **2209** **Habert** St. **20** Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

da.

How long in U.S., if of foreign birth?

yrs.

mos.

da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Unknown 1857

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, ____ hrs. or ____ min.

71

Unknown

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Don't Know

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Columbus Ohio

10. NAME OF FATHER

Bernard Mc. Daniels

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

12. MAIDEN NAME OF MOTHER

Mary Neil

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

14.

INFORMANT (Address)

Dr. Ignace de Loyola 2209 Habert

15.

FILED 22 1928

W. C. Stanley

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

June 21 9:15 1928

17.

I HEREBY CERTIFY That I attended deceased from **June 6**, 19**28**, to **June 21**, 19**28**, that I last saw him alive on **June 20**, 19**28**, and that death occurred, on the date stated above, at **9:15** a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis

90 B

97

CONTRIBUTORY (SECONDARY)

Arteriosclerosis

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?

No

DATE OF.....

WAS THERE AN AUTOPSY?

No

WHAT TEST CONFIRMED DIAGNOSIS?

Clinical Examination

(Signed)

Anthony A. Piekarski, M. D.

6/22, 1928 (Address)

1502 Cass Ave

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Calvary

6-23 1928

20. UNDERTAKER

ADDRESS

Arthur J. Donnelly

2037 Park St

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

