

Registration District No. 1003  
1003

Primary Registration District No. \_\_\_\_\_

Registrar's No. 2197

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: City Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 Hours  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County (26)  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3701 N. 9 Str  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 18  
year 1939 hour 4 minute 15 P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Hypertrophy  
Arteriosclerosis

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy See above

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME JAMES NEVILLE 140  
3. (b) If veteran, name war NO 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Hannah Neville 6. (c) Age of husband or wife if alive 58 years  
7. Birth date of deceased 1879 About  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day  
About 60 hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace St. Louis, Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business W.P.A.

MOTHER FATHER { 12. Name Patrick Neville  
13. Birthplace Ireland  
(City, town, or county) (State or foreign country)  
14. Maiden name Catherine Delaney  
15. Birthplace Ireland  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Joseph J. Neville  
(b) Address Joseph Neville 2033a College

17. (a) Joseph J. Neville (b) Date thereof 8-21-39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary  
M. A. Strick  
18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address 2117 E. Grand

19. (a) AUG 19 1939 (b) J. D. Pridemore  
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

ROY 5-17-39  
FORM 1 X 10311

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.

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**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*Frank A. Moore*

Licensed Embalmer No.....

*3041*

P. O. Address.....

*2117 E. Grand*

**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, above space should be left blank.**