

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 11 1942 318

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32279

State File No.

Registration District No.

Primary Registration District No. 1003

Registrar's No. 9128

1. PLACE OF DEATH:
(a) County.....
(b) City or town. St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
None 1828 Choteau /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. None
(Specify whether
In this community. 32 years
years, months or days)

3. (a) PRINT FULL NAME. JOHN SAMUEL NEEL
(b) If veteran, name war. no
(c) Social Security No. No

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced. single
(b) Name of husband or wife.....
(c) Age of husband or wife if alive..... years

7. Birth date of deceased. August 1st 1857
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>85</u>	<u>2</u>	<u>29</u>	hr. min.

9. Birthplace. Kentucky
(City, town, or county) (State or foreign country)

10. Usual occupation. R. R. Foreman

11. Industry or business. Retired

MOTHER FATHER
12. Name.....
13. Birthplace (City, town, or county) (State or foreign country) 9
14. Maiden name.....
15. Birthplace (City, town, or county) (State or foreign country) 9

16. (a) Informant. Ida Phillips
(b) Address. 1828 Choteau Ave.

17. (a) Burial (b) Date thereof. 11/2/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. St. Matthews

18. (a) Signature of funeral director. A. W. McLaughlin

(b) Address. 2301 Lafayette Ave.

19. (a) NOV 2 1942 (Date received local registrar)
J. F. Budick (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State. Missouri (b) County. 000 17 2
(c) City or town. St. Louis, Mo. 9 2
(If outside city or town limits, write "RURAL")
(d) Street No. 1828 Choteau Ave.
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 31
year 1942 hour 9:45 minute 7 M.

21. I hereby certify that I attended the deceased from Sept. 1
19 42 to 10-31 19 42
that I last saw him alive on 10-31 19 42
and that death occurred on the date and hour stated above.

Immediate cause of death.	Duration
<u>Myocarditis Chronic</u>	<u>2 mos.</u>
<u>Arterio Sclerosis</u>	<u>20 yrs.</u>
<u>sensitivity</u>	<u>20 yrs.</u>
Other conditions. <u>Fract Hip - old</u> (Include pregnancy within 3 months of death) <u>accident was</u>	
Major findings: Of operations. <u>None many</u> <u>years ago.</u>	
Of autopsy. <u>none</u>	

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

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) no
(b) Date of occurrence.....
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work?..... (Specify type of place)
(c) Means of injury. D
23. Signature. F. J. Suckley (M. D. or other) M.D.
Address. 1935 Park, Date signed. 11-1-42

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

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 L. R. Cooper
Licensed Embalmer No. 3633
P. O. Address 2317 Lafayette

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32279
Registrar's No. 9128

Registration District No. 318

Primary Registration District No. 1003

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:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
(Specify whether
In this community 32 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town.....
(If outside city or town limits, write "RURAL")

(d) Street No.....
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME.....

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased.....
(Month) (Day) (Year)

8. AGE: Years 85 Months 2 Days 4 (if less than one day)..... min.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Day.....
year 1942 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....
that I first saw him..... alive on..... 19.....
and that death occurred on the date and hour stated above.
(Immediate cause of death.....) Duration.....

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

10. Usual occupation.....

11. Industry or business.....

12. Name..... Unknown

13. Birthplace.....
(City, town, or county) (State or foreign country)

14. Maiden name..... Unknown

15. Birthplace.....
(City, town, or county) (State or foreign country)

16. (a) Informant.....
(b) Address.....

17. (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
(b) Address.....

19. (a) NOV 21 1942 J. F. Pudech
(Date received local registrar) (Registrar's signature)

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

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

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?.....
(City or town) (County) (State)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)

While at work?..... (c) Means of injury.....

23. Signature..... (M. D. or other).....
Address..... Date signed.....

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

SUPPLEMENTARY

MOTHER FATHER

