

7. S. No. 2
 FORM-5-43
 Rev. 5-17-39
 I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

32662

State File No. _____

FILED NOV 1 1944
 Registration District No. 898

Primary Registration District No. 1003 Registrar's No. 9085

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:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 1/2 Hrs.
(Specify whether years, months or days)
 In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County _____
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 1105 N. Channing
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Albert O'Neil
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced 1)
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased 9 2 44
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 hr. 30 min.

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

10. Usual occupation _____
 11. Industry or business _____

MOTHER FATHER { 12. Name Harvey O'Neil
 13. Birthplace Greenville Mississippi
(City, town, or county) (State or foreign country)
 14. Maiden name Shoaby James
 15. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mary T. Duwall
 (b) Address 2601 N. Whittier Street

17. (a) Burial (b) Date thereof OCT 26 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director J. B. Hudson
 (b) Address City Health Dept

19. (a) OCT 26 1944 (b) J. Hudson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 9 day 2
 year 44 hour 7 minute 25 a.m.
 21. I hereby certify that I attended the deceased from 9 - 2
1944, to 9 - 2, 1944.
 that I last saw him alive on 9 - 2, 1944,
 and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity Duration _____

Due to Unknown

Due to Unknown

Other conditions 159
(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)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place)
 While at work _____ (e) Means of injury _____

23. Signature J. P. Sankler (M. D. or other) _____
 Address 2601 N. Whittier St. Date signed 9/2/44

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.....

Licensed Embalmer No.....

P. O. Address.....

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, fact should be so stated above.