S. No. 2
M—2-43
5-17-39
P1 X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25921

FILED AUG 23 1945

Registration District No. ____ Primary Registration District No. L 8005 Registrar's No. 7174

1. PLACE OF DEATH:

(a) County: St. Louis

(b) City or town: (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Homer G. Phillips Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community: Life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: 006

(c) City or town: St. Louis 1721 (If outside city or town limits, write "RURAL")

(d) Street No.: 3206 Lucas Ave. 9
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME: Grace McNeal

3. (b) If veteran, name war ____

3. (c) Social Security No. ------

4. Sex: Female 3

5. Color or race: Col.

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Thomas McNeal

6. (c) Age of husband or wife if alive: 67 years

7. Birth date of deceased: November (Month) 23, (Day) 1896 (Year)

8. AGE: Years 48 Months 8 Days 20 If less than one day ____ hr. ____ min.

9. Birthplace: St. Louis (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business ____

FATHER
12. Name: Isaac Miller
13. Birthplace: Unk. (City, town, or county) Unk. 9 (State or foreign country)

MOTHER
14. Maiden name: Eveline Turner
15. Birthplace: Unk. (City, town, or county) Unk. 9 (State or foreign country)

16. (a) Informant: Thomas McNeal
(b) Address: 3206 Lucas Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8/17/45 (Month) (Day) (Year)
(c) Place: burial or cremation: Greenwood Cem.

18. (a) Signature of funeral director: Ellis Funeral Home
(b) Address: 2820 Stoddard St.

19. (a) AUG 17 1945 (Date received by registrar) J. F. Bredick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 12 year 1945 hour 7 minute 45 P.M.

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

Immediate cause of death: Acute Intestinal Obstruction — Duration ____
Adhesion

Due to ____

Due to ____

Other conditions (Include pregnancy within 3 months of death): 6 v

Major findings:
Of operations: 1 v

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 3

20. Signature: Alfred Stern (M. D. or other)

Address: Rupert Carson Date signed 8/17/45

(Licensed Embalmer's Statement on Reverse Side)

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 L. Boy

....., Registered Apprentice No. .....,

working under my personal supervision.

Signed Lonnie Boyl

Licensed Embalmer No. 2946

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