V. S. No. 2
100M—5-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 27 1946

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THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

1003

State File No. 18675

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 4425

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

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:
St. Louis Childrens Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days (Specify whether years, months or days)
In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Coles

(c) City or town Charleston
(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 Lowell Eugene McNeel

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Child

6. (b) Name of husband or wife _____

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

7. Birth date of deceased August (Month) 24 (Day) 1944 (Year)

8. AGE: Years 1 | Months 8 | Days 21. | If less than one day _____ hr. _____ min.

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

10. Usual occupation Child

11. Industry or business _____

FATHER
12. Name Stanley McNeel
13. Birthplace Charleston (City, town, or county) Illinois (State or foreign country)

MOTHER
14. Maiden name Lela Cougill
15. Birthplace Greenup (City, town, or county) Illinois (State or foreign country)

16. (a) Informant Stanley McNeel
(b) Address Charleston, Ill.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 5-16-46 (Month) (Day) (Year)
(c) Place: burial or cremation Charleston, Ill.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) MAY 16 1946 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 15 year 46 hour 3 minute 35 p.m.

21. I hereby certify that I attended the deceased from 5-10-1946 to 5-15-1946 that I last saw him alive on 5-15-1946 and that death occurred on the date and hour stated above.

Immediate cause of death Meningo-encephalitis of unknown origin

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

Duration

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 D. J. Bitter (M. D. or other)
Address 5th & Cedar Cuyler Date signed _____

(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.....

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

working under my personal supervision.

Signed John Ogorowski

Licensed Embalmer No. 3398

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.