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FILED JUL 30 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25150

State File No. ....

318

1003

6421

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_ Registrar's No. ....

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St Louis	c. LENGTH OF STAY (in this place) 1 day	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET (If rural, give location) 217-2017 Division	

3. NAME OF DECEASED (Type or Print) Willis Neale			4. DATE OF DEATH (Month) (Day) (Year) July 19 1949			
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 18-1887	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months 4	IF UNDER 1 YEAR Days 1	IF UNDER 1 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY unknown	11. BIRTHPLACE (State or foreign country) Paraloma Ark	12. CITIZEN OF WHAT COUNTRY? U.S.A
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13a. FATHER'S NAME Ben Neale	13b. MOTHER'S MAIDEN NAME Mattie Walker	14. NAME OF HUSBAND OR WIFE Rosie Mae Neale
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None	16. SOCIAL SECURITY NO. 495-12-7994	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Rosie Mae Neale 749 Westwood Dr.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, assthenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH Unk
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chr Nephritis with Azotemia		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 592X
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22. I hereby certify that I attended the deceased from July 18, 1949, to July 19, 1949, that I last saw the deceased alive on July 19, 1949, and that death occurred at 7:40 Pm., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J. Hedrick M.D.	23b. ADDRESS 2601 N Whittier	23c. DATE SIGNED 7-20-49
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 7-25-49	24c. NAME OF CEMETERY OR CREMATORY Father Dickson Cem.	24d. LOCATION (City, town, or county) (State) Kirkwood Mo, St Louis Co,
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DATE REC'D BY LOCAL REG. JUL 24 1949	REGISTRAR'S SIGNATURE J. W. Suter	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ellis Fun, Home 2820 Stoddard St
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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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Fulton E. Culkin

Licensed Embalmer No. 4198

P. O. Address Paris 13

**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.