

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26663

State File No. _____

FILED JUL 31 1953

318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 6708

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 6708			
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 town or township) St. Louis		c. LENGTH OF STAY (in this place) 1 week		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital				e. STREET ADDRESS (If rural, give location) 3653a Giles Ave.					
3. NAME OF DECEASED (Type or Print) a. (First) James		b. (Middle) C.		c. (Last) McNeil		4. DATE OF DEATH (Month) (Day) (Year) July 5 1953			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH July 2, 1921			
9. AGE (In years last birthday) 32		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repairman		10b. KIND OF BUSINESS OR INDUSTRY Public Serv. Co.		11. BIRTHPLACE (City and State or Foreign Country) Clinton Missouri			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Bernard McNeil		13b. MOTHER'S MAIDEN NAME Opal C. Carroll		14. NAME OF HUSBAND OR WIFE Helen McNeil			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> (If yes, give way or dates of service) W.W. #2		16. SOCIAL SECURITY NO. ---		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Helen McNeil - 3653a Giles Ave.					
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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary embolism ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cancerous, right testis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 12 hours 1 year	
19a. DATE OF OPERATION April 1953		19b. MAJOR FINDINGS OF OPERATION Generalized pelvic carcinoma				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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) 178X (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from April 1953, to July 5, 1953, that I last saw the deceased alive on July 5, 1953, and that death occurred at 5:30 P.M., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Cyril Costello, M.D.				23b. ADDRESS 3720 Washington		23c. DATE SIGNED 7-7-53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE July 9, 1953		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri			
DATE REC'D BY LOCAL REG. JUL 7 1953		REGISTRAR'S SIGNATURE J. Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE W. Kacker - Heldele		ADDRESS 3634 Gravois Ave.			

WRITE PLAINLY—USING UNFADEING 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, Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Frank J. Ireland
Licensed Embalmer No. *964*
P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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