

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

45481

State File No. ....

FILED JAN 19 1954

318

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Registrar's No. 12341

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____	
1. PLACE OF DEATH a. COUNTY <u>0</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS, MISSOURI</u>		c. LENGTH OF STAY (In this place) <u>8 days</u>	c. CITY OR TOWN <u>St. Louis</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>			e. STREET ADDRESS (If rural, give location) <u>4402 McPherson</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>HARRY</u> b. (Middle) <u>JOHN</u> c. (Last) <u>O'NEILL</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>December 30, 1953</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>June 20, 1893</u>	9. AGE (In years last birthday) <u>60</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>P.H.D.</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Teacher</u>	11. BIRTHPLACE (City and State, or Foreign Country) <u>St. Paul, Minn.</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <u>John J. O'Neill</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Kane</u>		14. NAME OF HUSBAND OR WIFE <u>Mabel O'Neill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Mabel O'Neill</u> ADDRESS <u>4402 McPherson Ave.</u>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac insufficiency</u>  ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 HRS.</u>  <u>10 Yrs.</u>
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) _____ (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>4200</u>			
22. I hereby certify that I attended the deceased from <u>12-21</u> , 1953, to <u>12-30</u> , 1953, that I last saw the deceased alive on <u>12-30</u> , 1953, and that death occurred at <u>1:20A</u> m., from the causes and on the date stated above.					
23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>			23b. ADDRESS <u>BARNES HOSPITAL</u>		23c. DATE SIGNED <u>12-30-53</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	24b. DATE <u>1-1-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Riverside Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Marshalltown, Iowa</u>		
DATE REC'D BY LOCAL REG. <u>DEC 30 1953</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Parker-Aldrich Funeral Home Webster Groves Mo.</u>		

WRITE PLAINLY—USING 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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Leslie Welch*.....

Licensed Embalmer No. *4395*

P. O. Address *Wester Grove*

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.