

FILED AUG 11 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25675

BIRTH NO. 58268-54 REG. DIST. NO. 717 PRIMARY REG. DIST. NO. 547 Registrar's No. 1849

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institutional residence, before admission) a. STATE <u>Mo</u> b. COUNTY <u>St Louis</u>	
b. CITY OR TOWN <u>Rich Hts Mo</u>	c. LENGTH OF STAY (in this place) <u>2 1/2 hrs</u>	c. CITY OR TOWN <u>Clayton 5 Mo</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Mary Hosp</u>		d. STREET ADDRESS (If rural, give location) <u>6515 San Bonita Ave</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>DANIEL</u>	b. (Middle) <u>JOSEPH</u>	c. (Last) <u>NEALON</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>July 28 - 1954</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>July 27 - 1954</u>	9. AGE (in years) (last birthday) <u>2</u> # UNDER 1 YEAR <u>0</u> Months <u>0</u> Days # UNDER 1 HRS. <u>2</u> Hours <u>30</u> Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Richmond Hts Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Stephen H Nealon</u>	13b. MOTHER'S MAIDEN NAME <u>Rose Marie Boland</u>	14. NAME OF HUSBAND OR WIFE <u>NONE</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Stephen H Nealon</u>	ADDRESS <u>6515 San Bonita</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congenital atelectasis</u>	DUPLICATE (b) <u>Unknown</u>		
ANTECEDENT CAUSES (Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.)	DUPLICATE (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 checked="" type="checkbox"/> NO <input 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)
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?

22. I hereby certify that I attended the deceased from Birth, 19___, to death, 19___, that I last saw the deceased alive on 7-28, 1954, and that death occurred at 2:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Erwin T. Huber MD</u>	(Degree or title)	23b. ADDRESS <u>1114 S. Hampton Blvd</u>	23c. DATE SIGNED <u>7-29-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>July 29 - 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cem</u>	24d. LOCATION (City, town, or county) (State) <u>St Louis Mo</u>
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DATE REC'D BY LOCAL REG. <u>7/29/54</u>	REGISTRAR'S SIGNATURE <u>Harold R. Spink</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Dockery</u>	ADDRESS <u>6536 Clayton Rd</u>
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(Licensed Embalmer) (Statement on Reverse Side)

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

Dr. E. J. Huber

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.

Not Embalmed
AKB King

Signed _____

Student
Student Embalmer

Licensed Embalmer No. _____

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.