

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023167

STATE FILE NUMBER
2 5758

FILED JUL 1 1959

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

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4028a Lexington</u>		Length of stay in 1b <u>40 Yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>4028a Lexington</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>H O S I E L E E M C N E A L</u>			4. DATE OF DEATH Month Day Year <u>6 14 1959</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 16, 1904</u>
9. AGE (In years last birthday) <u>54</u>		FUNDER 1 YEAR Months Days <u>9 28</u>	IF UNDER 24 HRS. Hours Min. <u>2</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Barber Shop</u>	11. BIRTHPLACE (City and state or country) <u>Bolivar, Tennessee</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>Beverly McNeal</u>	13b. MOTHER'S MAIDEN NAME <u>Rosa Bone Parte</u>
14. NAME OF HUSBAND OR WIFE <u>Oliver Mc Neal</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <u>Yes</u> or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>_____</u>
17. INFORMANT <u>Rosalee Spencer</u>		Address <u>4028a Lexington</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Prostate & Metastases</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>177+</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>May 1958</u> to <u>June 1959</u> and last saw her/him alive on <u>May 1959</u> Death occurred at <u>11:15 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>D. Richard M.D.</u> (Degree or title)		22b. ADDRESS <u>4901 A. Easton</u>	22c. DATE SIGNED <u>June 1959</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>6/19/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Jefferson Barracks, Mo.</u>
24. FUNERAL DIRECTOR <u>Charles J. Gates</u>		ADDRESS <u>4107 Finney</u>	25. DATE RECD. BY LOCAL REG. <u>JUN 17 '59</u>
26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u>			

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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
Signature of Student Embalmer

Signed *Gayton Swan*

Licensed Embalmer No.....4580.....

P. O. Address.....4107..Finney..

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.