

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	c. CITY OR TOWN Richmond Heights
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 7528 Ethel Ave.

3. NAME OF DECEASED (Type or print) JOHN JOSEPH O'NEIL			4. DATE OF DEATH Month Nov. Day 8, Year 1960		
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5. SEX M	6. COLOR OR RACE W.	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1882	9. AGE (last birthday) 78	IF UNDER 1 YEAR Months 8 Days 22	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant Clerk		10b. KIND OF BUSINESS OR INDUSTRY St. Louis Treasury Dept	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Tom O'Neil		13b. MOTHER'S MAIDEN NAME Annie Tierney		14. NAME OF HUSBAND OR WIFE Fannie O'Neil	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Address Fannie O'Neil 7528 Ethel Ave.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Gastric peptic ulcer	DUE TO (c) 4200	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <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 St. Louis, Mo.
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21. I attended the deceased from **1955** to **11/8/60** and last saw him alive on **11/8/60**.
Death occurred at **6:00 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Robert P. Ashworth M.D.</i>	22b. ADDRESS 3720 Washington Ave.	22c. DATE SIGNED 11/9/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Nov. 10, 1960	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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24. FUNERAL DIRECTOR ADDRESS A. H. Bocklage 6536 Clayton Rd.	25. DATE RECD. BY LOCAL REG. NOV 9 1960	26. REGISTRAR'S SIGNATURE <i>Keal Smith M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Stanley H. Dixon
Licensed Embalmer No. 419
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.