

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH - 61-015409

FILED MAY
AMENDED

4 1961

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

3918

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>ST LOUIS</u>	Length of stay in 1b <u>13 DAYS</u>	c. CITY OR TOWN <u>CHARLACK</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>INCARNATE WORD</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>8423 MIDLAND</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>T</u> Last <u>MCNEILL</u>			4. DATE OF DEATH Month <u>4</u> Day <u>22</u> Year <u>61</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-22-1879</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. POSTAL CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. POST OFFICE</u>	11. BIRTHPLACE (City and state or country) <u>DOUGLASS CO. ILL.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A</u>	

13a. FATHER'S NAME <u>THOMAS ILES MCNEILL</u>		13b. MOTHER'S MAIDEN NAME <u>CHARA DIANA MEADOWS</u>		14. NAME OF HUSBAND OR WIFE <u>LUKA MCNEILL</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. <u>490-36-7548</u>		17. INFORMANT Address <u>LUKA MCNEILL 8423 MIDLAND</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>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Carcinoma of Ascending Colon</u>	<u>6 mo</u>
	DUE TO (c) <u>153.0</u>	

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 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 a.m. p.m. Month, Day, Year	
---	--

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	COUNTY	STATE
--	--	------------------------------	--------	-------

21. I attended the deceased from <u>10-20-60</u> to <u>4-22-61</u> and last saw him alive on <u>4-22-61</u> Death occurred at <u>3:20 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
--	--

22a. SIGNATURE <u>H. J. Roeder M.D.</u>	22b. ADDRESS <u>9616 Roubidoux St.</u>	22c. DATE SIGNED <u>4-25-61</u>
--	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>4-25-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>VAL HALLA</u>	23d. LOCATION (City, town, or county) (State) <u>ST LOUIS MO</u>
---	-----------------------------	--	---

24. FUNERAL DIRECTOR <u>EARR HILKEMAN OVERLAND MO</u>	25. DATE RECD. BY LOCAL REG. <u>APR 25 1961</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith M.D.</u>
--	--	---

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Carl S. Hellman

Licensed Embalmer No. 3501

P. O. Address Greeland 147

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.