

OHIO DEPARTMENT OF HEALTH

COLUMBUS

CERTIFICATE OF DEATH

Department of Commerce — Bureau of the Census

Reg. Dist. No. 288
Primary Reg. Dist. No. B118State File No. 1974Registrar's No. 392

1. PLACE OF DEATH:

(a) County Cuyahoga
(b) Cleveland
(City, Village, Township)
(c) Name of hospital or institution:
Auditorium Hotel
(If not in hospital or institution, write street No. or location)
(d) Length of stay: In hospital or institution _____ (Days)
In this community Thirty yrs. (Years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ohio (b) County Cuyahoga
(c) City or village Cleveland
(If outside city or village, write RURAL)
(d) Street No. E 6 + St Clair Ave.
(If rural, give location)
FEB 1945
(e) If foreign born, how long in U. S. A.? _____ years.

3. FULL NAME

John H. Mc Neal
(a) If veteran, name war _____ (b) Social Security No. _____

4. Sex M 5. Color or race W. 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Alfracta Friedrich 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Aug 11 1877
(Month) (Day) (Year)

8. AGE: Years 67 Months 5 Days 5 If less than one day hr. min.

9. Birthplace Lorain Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation Attorney

11. Industry or business _____

12. Name John H. Mc Neal

13. Birthplace Lorain O.
(City, town, or county) (State or foreign country)

14. Maiden name Mary Friedrich

15. Birthplace Lorain Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant's signature D. Turkworth

(b) Address 502 Auditorium Bldg.

17. (a) Burial, cremation, or other: (b) Date Jan 16, 1945
(c) Place Johnston H. G.
(City, town, or county) (State or foreign country)

(d) E. H. Saxton 3848 A.
(Name of Embalmer) (Lic. No.)

18. (a) E. H. Saxton 1537
(Signature of Funeral Director) (Lic. No.)

(b) Address 13215 Detroit Ave.

19. (a) JAN 13 1945 Margaret Mc Ginty
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. Date of death: Month Jan. day 11th
year 1945 hour 10 minute 45 A.M.

21. I hereby certify that I attended the deceased from widowed after death to _____, 19____:

that I last saw him alive on _____, 19____:
and that death occurred on the date and hour stated above. Duration

Immediate cause of death

Fracture of skull, with laceration

and hemorrhage of brain by gunshot

Due to wound. Suicide. 1/11/45.

Due to 1945

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation

Major findings of autopsy No autopsy.

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Suicide,

(b) Date of occurrence 1/11/45.

(c) Where did injury occur? Cleveland, O.
(City or Village) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Auditorium Hotel.
(Specify type of place)

While at work? _____ (c) How did injury occur?
Suicide, gunshot wound of head.

23. Signature J. A. York - M.D. Colonel
(Specify if Doctor of Medicine or Osteopathy)

Address 712 Lakeside Ave., Date signed 1/11/45.