

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

15984

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
 Townshp..... Primary Registration District No. **1003**  
 City **St. Louis** (No. **City Hosp**)

File No.....  
 Registered No. **4456**  
 St..... Ward.....

**2. FULL NAME**

**Best Newhouse**  
 (a) Residence. No. **25** St. **25** Ward.....  
 (Usual place of abode) **Municipal Hospital** (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred **25** yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **single**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Nov. 3 - 1875**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
**55 5 4**

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work. **night watchman**  
 (b) General nature of industry, business, or establishment in which employed (or employer). **unknown**  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Illinois**

PARENTS  
 10. NAME OF FATHER **Unknown**  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**  
 12. MAIDEN NAME OF MOTHER **Unknown**  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT **Hospital Informant**  
 (Address) **Gracie Ross City Hospital**

15. FILED **APR 13 1931** REGISTRAR **Max C. Starn**

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **April 7th 1931**

17. I HEREBY CERTIFY, That I attended deceased from **Mar. 24th 1931** to **April 7th 1931** that I last saw him alive on **April 7th 1931**, and that death occurred, on the date stated above, at **9:30 a.m.**

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
**93C**  
**106A Ch. Myocarditis** (duration) yrs. mos. ds.  
 CONTRIBUTORY **Acute Bronchitis - not Tuberculous** (duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....  
 DID AN OPERATION PRECEDE DEATH? **No** DATE OF.....  
 WAS THERE AN AUTOPSY? **No**  
 WHAT TEST CONFIRMED DIAGNOSIS? **clinical**  
 (Signed) **George Simon**, M. D.  
**47** (Address) **City Hosp**

\*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Camp Point Ill** DATE OF BURIAL **4/11 1931**

20. UNDERTAKER **Ziegenheim Bros** ADDRESS **2621 Cherokee**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

