

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

41553  
State File No. 10676  
Registrar's No.

JAN 12 1940  
791  
Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County 1  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
City Hospital, #1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 weeks  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 1  
(c) City or town St. Louis MO  
Aclede Hotel (If outside city or town limits, write "RURAL")  
(d) Street No. 520 Chestnut Str  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Harry W Newhouse

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Cecilia Newhouse 6. (c) Age of husband or wife if alive 38 years

7. Birth date of deceased Feb 24 Th 1878  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
61 ----- 9 -- 19 - hr. min.

9. Birthplace St. Louis  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Hardware Salesman

11. Industry or business 0

12. Name August Newhouse

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

14. Maiden name Julia Kerner  
15. Birthplace Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature August Newhouse

(b) Address 3709 Kosuth Ave 1939

17. (a) Burial (b) Date thereof Dec 15 th  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Friedense Cam.

18. (a) Signature of funeral director Edward York

(b) Address 3516 n 14 th str

19. (a) 14 1939 (b) J. B. Baedek  
(Date received local registry) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 13,  
year 1939 hour 7:20 minute A. M.

21. I hereby certify that I attended the deceased from November 21, 1939, to December 13, 1939  
that I last saw him alive on December 13, 1939  
and that death occurred on the date and hour stated above.

Immediate cause of death Syphilitic Aortitis  
Due to Syphilis  
Other conditions (Include pregnancy within 3 months of death)  
Major findings: Of operations  
Of autopsy

Duration  
PHYSICIAN  
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)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (a) Means of injury  
23. Signature Geo. M. Pike (M. D. or other)  
Address 1515 Lafayette, Date signed 12/13/39

**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed



Licensed Embalmer No. 1591

P. O. Address 4106 Belmont

**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 this body is not embalmed, above space should be left blank.**