

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.

MAR 12 1940
 1940

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Park Lane Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 weeks (Specify whether
 In this community 35 years (months or days)

3. (a) PRINT FULL NAME CHAS. G. NEWBERRY
 3. (b) If veteran, name war _____ 3. (c) Social Security No. 493-07-5451

4. Sex Male 5. Color of race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Anna Newberry 6. (c) Age of husband or wife if alive 52 years
 7. Birth date of deceased July 22 1886
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>53</u>	<u>7</u>	<u>1</u>	hr. min.

9. Birthplace Farrar Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation Wachman

11. Industry or business Indiana Union Shoe Co.

MOTHER { 12. Name Thomas Newberry
 13. Birthplace Farrar Mo.
 (City, town, or county) (State or foreign country)
 14. Maiden name Anderson
 15. Birthplace Anderson
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Anna Newberry
 (b) Address 4609 Newport Ave

17. (a) Interred (b) Date thereof Feb. 26 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Cepherdian Cemetery

18. (a) Signature of funeral director Edwin J. Smith
 (b) Address 1936 St. Louis Ave

19. (a) FEB 26 1940 (Registrar's signature) J. F. Beck

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County _____
 (c) City or town St. Louis 15
 (If outside city or town limits, write "RURAL")
 (d) Street No. 4609 Newport Ave
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Feb. day 23
 year 1940 hour 4 minute 50 A. M.
 21. I hereby certify that I attended the deceased from Jan 10
1940, 19____, to Feb. 23, 1940;
 that I last saw him alive on Feb. 23, 1940;
 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Empyema of base of lungs</u>	<u>?</u>
Due to _____	_____
Due to _____	_____
Other conditions (Include pregnancy within 3 months of death)	_____
Major findings: Of operations <u>Stenosis of Bile duct</u>	PHYSICIAN Underline the cause to which death should be charged statistically.
Of autopsy _____	

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? _____

23. While at work _____ (Specify type of place)
 (e) Means of injury _____
 23. Signature Dr. J. Sweet (M.D. or other) M.D.
 Address 4930 Euclid Blvd. Date signed _____

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. *3737*

P. O. Address *1936 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 this body is not embalmed, above space should be left blank.