

FILED DEC 23 1946

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1003

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County St. Louis Missouri  
(b) City or town St. Louis Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Louis City Hospital - Max C. Starkloff  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 3000  
(c) City or town St. Louis 12  
(If outside city or town limits, write "RURAL") 8  
(d) Street No. 6977 Cleatha  
Memorial (If rural, give location) 0  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

THOMAS NEWTON

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W.  
6. (a) Single, widowed, married, divorced M  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Nov 15 1866  
(Month) (Day) (Year)

8. AGE: Years 80 Months 1 Days 2 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business Labour

12. Name unknown

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

14. Maiden name unknown

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant Richard Newton

(b) Address 6977 Cleatha

17. (a) Burial (b) Date thereof Dec 19-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews

18. (c) Signature of funeral director Paula Guinness, Home

(b) Address 3029 Lafayette

19. (a) DEC 19 1946 (b) \_\_\_\_\_  
(Date received from registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 17th  
year 1946 hour 6:08 minute P M.  
21. I hereby certify that I attended the deceased from 12/13/46  
to Dec. 17th 19 46  
that I last saw him im alive on Dec. 17th 19 46  
and that death occurred on the date and hour stated above.

Immediate cause of death Queinena of  
The Bosphorus & Greek  
Cerebral fistula  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations H/O  
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? \_\_\_\_\_

While at work? \_\_\_\_\_  
Signature P. Thomas (M. 12/18/46)  
Address 1515 Lafayette Date signed \_\_\_\_\_

MOTHER FATHER

PHYSICIAN  
Underline the cause to which death should be charged statistically.

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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.....

*David Van Fossom*

Licensed Embalmer No. *4245*

P. O. Address *3029 Lafayette*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**