No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

41650

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 23 1946

Registration District No. #20046 318

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 42847

Registrar's No. 10940

1. PLACE OF DEATH:

(a) County

(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 St. Louis, Mo. (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No. 1431 Dolman St.
Memorial (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Newton Presson

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex male

5. Color or race white

6. (a) Single, widowed, married, divorced widower

6. (b) Name of husband or wife unknown

6. (c) Age of husband or wife if alive years

7. Birth date of deceased May (Month) 1st (Day) 1867 (Year)

8. AGE: Years 79 Months 7 Days 18 If less than one day hr. min.

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

10. Usual occupation None

11. Industry or business

FATHER
12. Name Davie Presson
13. Birthplace Tennessee (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Bivens
15. Birthplace Tennessee (City, town, or county) (State or foreign country)

16. (a) Informant Ralph Presson
(b) Address 1431 Dolman St.

17. (c) removal (Burial, cremation, or removal) (b) Date thereof 12-22-46 (Month) (Day) (Year)
(c) Place: burial or cremation Sikeston, Missouri

18. (a) Signature of funeral director E. J. Schnur
(b) Address 3125 Lafayette Ave.

19. (a) DEC 20 1946 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 19th year 1946 hour 5:05 minute p M.

21. I hereby certify that I attended the deceased from 11/7/46, 19, to Dec. 19th, 1946 that I last saw him alive on Dec. 19th, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Asterio-Sclerotic heart

Due to Disease

Due to Decompensation

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy None

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?
(Specify type of place)

While at work? (e) Means of Injury

23. Signature [signature] 1515 Lafayette 12/19/46 (M. D. or other)

Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Jos B Vollmer

Licensed Embalmer No. 4014

P. O. Address St Louis 4 Mo

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, fact should be so stated above.