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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

FILED JUN 30 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 22531  
Registrar's No. 5906

Registration District No. 318

Primary Registration District No. 1003

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:  
3844 Mc Ree Ave.  
(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

3. (a) PRINT FULL NAME Robert A. Newell

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

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Nov. 8th. 1876  
(Month) (Day) (Year)

8. AGE: Years 70 Months 7 Days 8  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Steamfitter

11. Industry or business Retired

12. Name Patrick Newell

13. Birthplace Ireland (Elizabeth O'Connor) (foreign country)

14. Maiden name Elizabeth O'Connor

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

16. (a) Informant Miss. Ann Newell

(b) Address 3844 McRee Ave.

17. (a) Burial (b) Date thereof 6/19/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Sullivan Funeral Dir

(b) Address 2849 North Euclid Ave.

19. (a) JUN 17 1947 (b) J. J. Brudeck (Registrar's signature)

(Date received local registrar) (Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County *ool*  
(c) City or town St. Louis (If outside city or town limits, write "RURAL")  
(d) Street No. 3844 McRee Ave. (If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 16th.  
year 1947 hour 6.15 minute P.M.

21. I hereby certify that I attended the deceased from April 19, 1947, to June 17, 1947

that I last saw him alive on June 11, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Chronic myocarditis

Due to senility

Due to \_\_\_\_\_

Other conditions: angina (Right side) M32  
(Include pregnancy within 3 months of death)

Major findings: Of operations: none

Of autopsy: none

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) none

(b) Date of occurrence none

(c) Where did injury occur? none (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) (e) Means of injury \_\_\_\_\_

23. Signature Preston C Hall (M. D. or other) M.D.

Address 3902 Lafayette Date signed 6/17/47

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

Dr. Preston C. Hall  
3902 Lafayette Ave.  
GR. 8074

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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.....

*Robert L. Bankman*

Licensed Embalmer No. *3553*

P. O. Address.....

**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.**