

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

25885
State File No.
Registrar's No. 6991

FILED AUG 4 1947
Registration District No. 818

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County ST LOUIS MO
(b) City or town ST LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution DE PAUL HOSP.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 DAYS (Specify whether)
55 YRS.
In this community 55 YRS. years, months or days

3. (a) PRINT FULL NAME SUSAN M. NEWMAN (NEUMAN)

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

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife FRANK R. NEWMAN 6. (c) Age of husband or wife if alive DEC'D years
7. Birth date of deceased AUG 12TH 1869 (Month) (Day) (Year)

8. AGE: Years 77 Months 11 Days 14 If less than one day hr. min.

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

10. Usual occupation HOUSE WORK.

11. Industry or business AT HOME

12. Name MICHAEL DAVIDSON

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

14. Maiden name MATILDA DEHRING

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

16. (a) Informant Mrs. Carrie J. Bruch

(b) Address 5238 M. E. Anderson Ave.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7-29-47 (Month) (Day) (Year)

(c) Place: burial or cremation OLD S.S. PETER - PAUL

18. (a) Signature of funeral director Brookland, Ind. Co.

(b) Address 1827 Hogan Str.

19. (c) JUL 28 1947 (Date received local registrar) (d) J. J. Bradeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 000
(c) City or town ST. LOUIS (If outside city or town limits, write "RURAL")
(d) Street No. 5822 FERRIS AVE (If rural, give location)
7 (e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JULY day 26TH
year 1947 hour 650 minute A. M.

21. I hereby certify that I attended the deceased from 22 July 1947 to 26 July 1947
that I last saw h.e. alive on 25 July 1947
and that death occurred on the date and hour stated above. Duration

Immediate cause of death Pneumonia - Bronchial

Due to Cerebral hemorrhage.

Due to Hypertension & arteriosclerosis

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

PHYSICIAN

Underline the cause of 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 Marlin C. Spoorman (M. D. or other) M.D.

Address 3633 N. Newstead Date signed 26 July 47

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. _____

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.