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STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14504

Registration District No. _____

Primary Registration District No. _____

1003

Registrar's No. 4160

1. PLACE OF DEATH:

(a) County _____
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ST. LOUIS MATERNITY HOSPITAL
(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 INFANT MALE NEWTON

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 _____

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

7. Birth date of deceased: APRIL 4 48
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 1 hr. 53 min.

9. Birthplace: ST. LOUIS MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name ROBERT E. NEWTON

13. Birthplace ST. LOUIS MISSOURI
(City, town, or county) (State or foreign country)

14. Maiden name DOROTHY MAE FAIRBANK

15. Birthplace ST. LOUIS MISSOURI
(City, town, or county) (State or foreign country)

16. (a) Informant ST. LOUIS MATERNITY HOSPITAL
(b) Address 630 SO. KINGSHIGHWAY

17. (a) Anatomical Board (b) Date thereof APR 30 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Anatomical Board

18. (a) Signature of funeral director Robert Newton Newton

(b) Address 4104 Washington

19. (a) APR 30 1948 (b) J. F. Bredech
(Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County _____
(c) City or town CLAYTON
(If outside city or town limits, write "RURAL")
(d) Street No. 254 SO. BRENTWOOD
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL 4
year 48 hour 7:07 P. M. minute _____ M.

21. I hereby certify that I attended the deceased from APRIL
4 5:25 P.M. 1948 to APRIL 4 1948
that I last saw him alive on APRIL 4 1948
and that death occurred on the date and hour stated above.

Immediate cause of death

Stopped breathing
Prematurity

Due to _____

Due to _____

Other conditions
(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. F. Bredech (M. D. or other) MD

Address 65 Sun Over Date signed 4/27/48

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

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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.....

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.