

No. 300  
-10-47  
-17-39  
PI 3906

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics  
FILED DEC 14 1948

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

38483  
State File No. 10518  
Registrar's No.

Registration District No. 318 Primary Registration District No. 1005

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:  
4672 Tennessee ave.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4672 Tennessee ave.  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Belle Newman  
3. (b) If veteran, name war no  
3. (c) Social Security No. no

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month December day 3  
year 1948 hour 4 minute 20 AM  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced. (Single)  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years

Immediate cause of death: Coronary thrombosis  
Duration \_\_\_\_\_

7. Birth date of deceased April 11 1874  
(Month) (Day) (Year)  
8. AGE: Years 74 Months 7 Days 22  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

9. Birthplace Springfield Missouri  
(City, town, or county) (State or foreign country)  
10. Usual occupation retired  
11. Industry or business Laundry Worker

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

MOTHER FATHER }  
12. Name Robert W. Newman  
13. Birthplace London England 4  
(City, town, or county) (State or foreign country)  
14. Maiden name Amanda Miller  
15. Birthplace Ohio 1  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Bertha Griggs  
(b) Address 4672 Tennessee ave.  
17. (a) Burial (b) Date thereof Dec. 6-48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Park Lawn Cemetery  
18. (a) Signature of funeral director C. Hoffmeister U. & L. Co.  
(b) Address 7814 S. Broadway  
19. (a) DEC 4 1948 (b) J. B. Basater  
(Date received local registrar) (Registrar's signature)

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) (c) Means of injury \_\_\_\_\_  
23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed 12/4/48

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

---

---

**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 *Louis E. Hoffmeister*  
Licensed Embalmer No. *3471*  
P. O. Address *7814 S Broadway*

**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.**