

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32195**

FILED OCT 10 1951

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 3199

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

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Koch (rural)</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>	
c. LENGTH OF STAY (In this place) <u>326 days</u>		d. STREET ADDRESS (If rural, give location) <u>2651 Lucas</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Robert Koch Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>John</u>	b. (Middle) <u>D.</u>	c. (Last) <u>Newton</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>9-18-51</u>
-------------------------------------	------------------------	-----------------------	-------------------------	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Separated</u>	8. DATE OF BIRTH <u>10-8-92</u>	9. AGE (In years last birthday) <u>58</u>	IF UNDER 1 YEAR (Month) (Day) (Hour) (Min.) <u>11/18</u>	IF UNDER 24 HRS. (Hour) (Min.) _____
--------------------	-------------------------------	---	---------------------------------	---	--	--------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>West Station, Mississippi</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--	--	--	--

13a. FATHER'S NAME <u>John Newton</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Gordon</u>	14. NAME OF HUSBAND OR WIFE <u>Mattie Foster Newton</u>
---------------------------------------	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>??</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Hospital Records, Robt. Koch Hosp.</u>	ADDRESS _____
--	-----------------------------------	---	---------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs (?)</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Tuberculosis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>002X</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------------	--	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 10-27-50, to 9-18-51, 1951, that I last saw the deceased alive on 9-18-, 1951, and that death occurred at 11 A. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Robert Kiyasu M.D.</u>	23b. ADDRESS <u>Robert Koch Hospital</u>	23c. DATE SIGNED <u>9-19-51</u>
--	--	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>9-24-51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>
---	--------------------------	---	--

DATE REC'D BY LOCAL REG. <u>9-21-51</u>	REGISTRAR'S SIGNATURE <u>Herbert R. Donke MB</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Athena Bros.</u>	ADDRESS <u>3644 Finney</u>
---	--	--	----------------------------

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed ADP Richards

Licensed Embalmer No. 2928

P. O. Address 2625 Glasgow

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.