

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33789

State File No. ....

FILED SEP 24 1953

Registrar's No. 8661

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 33789		Registrar's No. 8661		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____						
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			c. LENGTH OF STAY (in this place) _____			c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital				e. STREET ADDRESS (If rural, give location) 20 2740 Madison						
3. NAME OF DECEASED (Type or Print) Raymond			a. (First)		b. (Middle) Newsome		c. (Last)			
4. DATE OF DEATH (Month) (Day) (Year) 9 4 53			5. SEX Male 2			6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2		
8. DATE OF BIRTH August 19, 1898			9. AGE (In years last birthday) 55		IF UNDER 1 YEAR Months _____		IF UNDER 24 HRS. Days _____ Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Unknown			11. BIRTHPLACE (City and State or Foreign Country) Indiana (Town Unknown) /			12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Gurny Newsom			13b. MOTHER'S MAIDEN NAME Geneva Scott			14. NAME OF HUSBAND OR WIFE None				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown			16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME <i>Lue Winnie Deberry</i>			ADDRESS 2620 Baldwin St		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)			MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
			I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Primary Bronchogenic Carcinoma						Undt.	
			ANTECEDENT CAUSES							
			*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.							
			Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.							
			DUE TO (b) _____							
			DUE TO (c) _____							
			II. OTHER SIGNIFICANT CONDITIONS							
			Conditions contributing to the death but not related to the disease or condition causing death.							
			Metastasis to Larynx and Cervical Nodes						Undt.	
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) _____			162X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m. _____			21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21f. HOW DID INJURY OCCUR? _____				
22. I hereby certify that I attended the deceased from 4-7-1953, to 9-4-1953, that I last saw the deceased alive on 9-4-1953, and that death occurred at 11:40AM., from the causes and on the date stated above.										
23a. SIGNATURE (Degree or title) <i>P.S. Braithwaite, M.D.</i>					23b. ADDRESS 2601 N. Whittier			23c. DATE SIGNED 9-5-53		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 9/6/53		24c. NAME OF CEMETERY OR CREMATORY _____			24d. LOCATION (City, town, or county) (State) Anderson, Indiana			
DATE REC'D BY LOCAL REG. SEP 5 1953		REGISTRAR'S SIGNATURE <i>J. Earl Smith M.D.</i>			25. FUNERAL DIRECTOR'S SIGNATURE <i>H.D. Richardson</i>			ADDRESS 2625 Glasgow		

WRITE PLAINLY—USING 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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Andrew Richardson*

Licensed Embalmer No. *485*

P. O. Address *2625 St*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.