

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

FILED FEB 2 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3123

State File No.
Registrar's No. **0689**

BIRTH NO. REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois	
b. CITY OR TOWN St. Louis		c. CITY OR TOWN RICHVIEW	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place)		e. STREET ADDRESS (If rural, give location) 8120 8	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis CHILDRENS			

3. NAME OF DECEASED (Type or Print) DOYNA KAY NEWCOMB			4. DATE OF DEATH (Month) (Day) (Year) 1-21-54			
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 0	8. DATE OF BIRTH 7-8-50	9. AGE (In years last birthday) 3	IF UNDER 1 YEAR Days 6	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) CENTRALIA - ILL		12. CITIZEN OF WHAT COUNTRY? USA.

13a. FATHER'S NAME CECIL W. Newcomb	13b. MOTHER'S MAIDEN NAME EONA RAHN	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS D. SHELTER - 500 So. Kingshighway

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) Dysenteritis colon		DUPLICATE SIGNATURE Dysenteritis colon		
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUPLICATE SIGNATURE Dysenteritis colon		
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 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 578X
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22. I hereby certify that I attended the deceased from **1-12**, 19**54**, to **1-21**, 19**54**, that I last saw the deceased alive on **1-21**, 19**54**, and that death occurred at **6:10 p m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) H. J. Holtzman, MD	23b. ADDRESS 500 South Kingshighway	23c. DATE SIGNED 1-21-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 1-21-54	24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State) Centralia Ill.		

DATE REC'D BY LOCAL REG. JAN 22 1954	REGISTRAR'S SIGNATURE Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS A.H. Hoppe 4704 Washington Ave.
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(Licensed Embalmer's Statement on Reverse Side)

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..... *Paul G. Wachter*

Licensed Embalmer No. *77*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.