

FILED FEB 2 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3127**
Registrar's No. **0591**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
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 type="checkbox"/> No <input checked="" type="checkbox"/> 2299	
d. FULL NAME OF HOSPITAL OR INSTITUTION Dona Homer Phillips Hosp				e. STREET ADDRESS (If rural, give location) 1322 No 19th St			
3. NAME OF DECEASED (Type or Print)		a. (First) NETTIE		b. (Middle) M		c. (Last) NEWSON	
4. DATE OF DEATH		(Month) JAN		(Day) 16		(Year) 1954	
5. SEX Female		6. COLOR OR RACE NEGRO		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED		8. DATE OF BIRTH 2 Mar 1936	
9. AGE (In years last birthday) 17		IF UNDER 1 YEAR Months 10		IF UNDER 1 HRS. Days 14		Hours 14 Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (City and State or Foreign Country) St Louis Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME James Newson		13b. MOTHER'S MAIDEN NAME Calvine Spann		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give year or date of service) NONE		17. INFORMANT'S SIGNATURE OR NAME Calvine Newson ADDRESS 1322 No 19th			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Status Asthmaticus ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <input checked="" type="checkbox"/> DUE TO (c) <input checked="" type="checkbox"/> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. NONE				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION NONE		19b. MAJOR FINDINGS OF OPERATION <input checked="" type="checkbox"/>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <input checked="" type="checkbox"/>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input checked="" type="checkbox"/>		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) _____ (Day) _____ (Year) _____ (Hour) _____ m. <input checked="" type="checkbox"/>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 241X			
22. I hereby certify that I attended the deceased from Mar. 28 , 19 53 , to Jan. 15 , 19 54 ; that I last saw the deceased alive on Jan. 15 , 19 54 , and that death occurred at 9:25 p.m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Alvamoore M.D.				23b. ADDRESS 4501st Easton Ave.		23c. DATE SIGNED 1-19-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 2/25/54		24c. NAME OF CEMETERY OR CREMATORY Oakdale Cemetery		24d. LOCATION (City, town, or county) (State) St Louis County Mo	
DATE REC'D BY LOCAL REG. JAN 20 1954		REGISTRAR'S SIGNATURE Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Reliable Funeral Sys ADDRESS 4500 Newburg			

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

Student.....
Signature of Student Embalmer

no 3278

Signed Paul V. Freeman

Licensed Embalmer No. 465

P. O. Address 4729

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.