

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-027800

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 224

AMENDED

FILED AUG 11 1961

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO.

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>St Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Normandy</u>		Length of stay in 1b <u>1 day</u>	c. CITY OR TOWN <u>Overland</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Normandy Hosp</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>9611 Whistler Ct</u>		
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>H J</u> Last <u>Newport</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>4</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5/15/1881</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Radio Dispatcher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Overland Police Dept</u>	11. BIRTHPLACE (City and state or country) <u>St Louis Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>John Newport</u>		13b. MOTHER'S MAIDEN NAME <u>Mary (do not know)</u>		14. NAME OF HUSBAND OR WIFE <u>Amelia Newport</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>			17. INFORMANT Address <u>Patricia Silvus 9611 Whistler Ct</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct.</u> DUE TO (b) <u>Coronary Occlusion</u> DUE TO (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>Jan 30 1960</u> and last saw him alive on <u>Aug 4 1961</u> . Death occurred at <u>10:30 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>L.R. Williams, D.O.</u> (Degree or title)			22b. ADDRESS <u>10426 Lackland</u>		22c. DATE SIGNED <u>8-5-61</u> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/7/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill</u>		23d. LOCATION (City, town, or county) <u>St Louis Mo</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Ortmann F Home 9222 Lackland Overland Mo</u>			25. DATE RECD. BY LOCAL REG. <u>8-5-61</u>		REGISTRAR'S SIGNATURE <u>John W. [Signature]</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 _____
Signature of Student Embalmer

Signed Al C Ostmann

Licensed Embalmer No. 3478

P. O. Address _____

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.