

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

**6990**

**1. PLACE OF DEATH**

County..... Registration District No. 701  
Township..... Primary Registration District No. 1003  
City St. Louis (No. Ev. Route to City Stop #1)

File No. ....  
Registered No. 1855  
St. .... Ward)

**2. FULL NAME**

Newton K. Heninger

(a) Residence. No. 3603 Evans Ave., 11 Ward. (If nonresident, give city or town and State)  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS.**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>abt</u>	<u>71</u>	<u>✓</u>	<u>✓</u>	

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Street Cleaner  
(b) General nature of industry, business, or establishment in which employed (or employer) City of St. Louis  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Unknown  
(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown  
(STATE OR COUNTRY)

14. INFORMANT J.W. Henner  
(Address) Towners Office

15. FILED 21 1933 May 21 1933  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-17-1930 19

17. The Physician or Attending  
I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....  
that I last saw h..... alive on ..... 19..... and that death occurred, on the date stated above, at 10:00 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Chronic Myocarditis  
73c (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 900 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH.....

8. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) John Schurely M.D.  
2/10 1930 (Address) Deputy Coroner

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St. Matthews Cem DATE OF BURIAL 2/21 1930

20. UNDERTAKER Ziegeheier Bros. ADDRESS 264 Cherokee St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A

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