WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

FEB 27 1934

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

Do not use this space.

33226

File No. .....

Registered No. 886

1. PLACE OF DEATH

County .....

Township .....

City St Louis Mo (No. ....., ... St. ..... Ward)

Registration District No. 791

Primary Registration District No. 1003

2. FULL NAME Ralph Newson

(a) Residence, No. 2600 Mills St. 21 Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred ' yrs. 4 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*)
Male	Colored	infant

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 21 - 1933

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	4	2	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. .....

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. infant

10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) St Louis (STATE OR COUNTRY) Mo

FATHER

13. NAME James Newson

14. BIRTHPLACE (CITY OR TOWN) Halby Springs (STATE OR COUNTRY) Miss

MOTHER

15. MAIDEN NAME Calvine Span

16. BIRTHPLACE (CITY OR TOWN) Macon (STATE OR COUNTRY) Miss

17. INFORMANT James Newson (ADDRESS) 2600 Mills St.

18. BURIAL, CREMATION, OR REMOVAL

PLACE Father Dyer DATE Jan 25 1934

19. UNDERTAKER Gis Funeral Home (ADDRESS) 2820 Goddard St.

20. FILED ..... 19 J Bueck Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1 - 23 1934

22. I HEREBY CERTIFY, That I attended deceased from Jan 23 1934, to ....., 19....

I last saw him alive on Jan 23, 1934. Death is said to have occurred on the date stated above, at 1:30 p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Acute Enteritis	1 W
1 D	

Other contributory causes of importance: 1490

Name of operation ..... Date of .....

What test confirmed diagnosis? Clinical Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) Vincent J Mueller, M. D.

(Address) 2335 Fr ....