

791

Registration District No. **1008** Primary Registration District No. _____

1. PLACE OF DEATH: **1008** **SEP 14 1939**

(a) County **St. Louis Mo** **3**
(b) City or town **St. Louis Mo**
(c) Name of hospital or institution **5333 Easton**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2** (Specify whether)

In this community _____
years, months or days **250**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **L**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **2870 Bell Ave**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME **WILLIAM-NEWTON**
(b) If veteran, name war **No**
(c) Social Security No. **No**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **1st**
year **1939** hour **5:45** minute _____ P. _____ M.

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Hollie** 6. (c) Age of husband or wife if alive **55** years
7. Birth date of deceased **June 15, 1884**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death **Coronary Sclerosis;** Duration _____

8. AGE: Years **55** Months **1** Days **15** If less than one day _____ hr. _____ min.

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

9. Birthplace **St. Louis Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Bar tender**

MOTHER FATHER

11. Industry or business _____
12. Name **Harry Quinton**
13. Birthplace **St. Louis Mo**
(City, town, or county) (State or foreign country)
14. Maiden name **Hollie Beale**
15. Birthplace **St. Louis Mo**
(City, town, or county) (State or foreign country)

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature **Hollie Newton**
(b) Address **6510 Bell Ave**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **L**

17. (a) **Burial** (b) Date thereof **Aug 4, 1939**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Memorial Park**

While at work _____ (Specify type of place)
(e) Means of injury _____

18. (a) Signature of funeral director **J. Quinn**
(b) Address **1589 Union**
19. (a) **AUG 3 1939** (b) **J. D. Bidlock**
(Date received local registrar) (Registrar's signature)

23. Signature **Joseph M. Quinn** (M. D. or other) _____
Address **Regulatory** Date signed **8/3**

WHITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

1 X 19311

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed

Ben Fein

Licensed Embalmer No. 1591

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 this body is not embalmed, above space should be left blank.