

Registration District No. **791** Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis**
 (b) City or town **St. Louis**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
BARNES HOSPITAL
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME **Dacey Maye Newman**3. (b) If veteran, name war **No.** 3. (c) Social Security No. **None**4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**6. (b) Name of husband or wife **Orlin T.** 6. (c) Age of husband or wife if alive **60** years7. Birth date of deceased **May 6 1880**
(Month) (Day) (Year)8. AGE: Years **60** Months **5** Days **22** If less than one day _____ hr. _____ min.9. Birthplace **Illinois**
(City, town, or county) (State or foreign country)10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Moses Shettleworth**18. Birthplace **Illinois**
(City, town, or county) (State or foreign country)14. Maiden name **Lydis Bodine**15. Birthplace **Illinois**
(City, town, or county) (State or foreign country)16. (a) Informant's own signature **O. T. Newman**(b) Address **Carbondale, Ill.**17. (a) **Removal** (b) Date thereof **10/29/40**
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **Carbondale, Ill.**18. (a) Signature of funeral director **Albert H. Hoppe**(b) Address **4700 Washington Ave.**19. (a) **OCT 29 1940** (b) *[Signature]*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Illinois** (b) County _____
 (c) City or town **Carbondale** **NR**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **312 West Walnut**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **28**
year **1940** hour **1** minute **30** P.M.21. I hereby certify that I attended the deceased from
October 24, 19**40** to **October 28**, 19**40**;
that I last saw ~~her~~ **her** alive on **October 28**, 19**40**;
and that death occurred on the date and hour stated above.
Immediate cause of death **Liver insufficiency** Duration _____Due to **Carcinoma of ascending colon
with metastases to liver, pleura,
peritonium, regional lymph nodes.**Other conditions _____
(Include pregnancy within 3 months of death)Major findings:
Of operations _____Of autopsy **As above**

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?

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

23. Signature **FR Bradley** (M. D. or other) _____
Address **BARNES HOSPITAL** Date signed **10-28-40**

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

J. G. Sullivan

Licensed Embalmer No. *1122*

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.