

Registration District No. 1003

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 Homer G Phillips
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 14 days
In this community 16 years 0 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Newton Bates

3. (b) If veteran, name war Unk 3. (c) Social Security No. Unk

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife Unk 6. (c) Age of husband or wife if alive Unk years

7. Birth date of deceased August 20, 1897
(Month) (Day) (Year)

8. AGE: Years 44 Months 0 Days 2 If less than one day _____ hr. _____ min.

9. Birthplace Porter Pa
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Arthur Bates

13. Birthplace La
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Chase

15. Birthplace La
(City, town, or county) (State or foreign country)

16. (a) Informant Rosene A Spotts Sec'y

(b) Address 2601 N Whittier

17. (a) Anatomical Board (b) Date thereof 9-25-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pattee Hill

18. (a) Signature of funeral director John H. Hatcher

(b) Address City Health Department

19. (a) SEP 24 1941 (b) J. J. Beckwith
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St Louis 19 17
(If outside city or town limits, write "RURAL") 4409 Olive St 7
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 22
year 1941 hour 10:15 minute _____ A. M.

21. I hereby certify that I attended the deceased from August 8 41 to August 22 19 41
that I last saw him in alive on August 22 19 41
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia Duration 18 days

Due to _____

Due to _____

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) (e) Means of injury _____

23. Signature J. W. Johnson (M. D. or other) 0

Address 2601 N Whittier Date signed 8-25-41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

Licensed Embalmer No.....

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, fact should be so stated above.