

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **16497**
Registrar's No. **A299**

FILED **MAY 23 1942**
Registration District No. **791**

Primary Registration District No. **1003**

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

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1. PLACE OF DEATH:

(a) County St. Louis Missouri

(b) City or town St. Louis Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Missouri Baptist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether
years, months or days) (Specify whether

In this community..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Grace Newton

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

4. Sex female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Robert Newton 6. (c) Age of husband or wife if alive 38 years

7. Birth date of deceased Feb 15 1905
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

37 2 18 hr. min.

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

10. Usual occupation Housewife

11. Industry or business.....

MOTHER FATHER { 12. Name Robert Johnson

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

14. Maiden name Ester Lough

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

16. (a) Informant Robert Newton

(b) Address St. Clair Mo.

17. (a) Removal (b) Date thereof 5/16/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Clair Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington

19. (a) MAY 15 (b) J. F. Budick
(Date received from registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin

(c) City or town St. Clair (If outside city or town limits, write "RURAL") N.R.

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 13 year 1942 hour 7 minute 9 M.

21. I hereby certify that I attended the deceased from April 42 to May 13 1942 and that death occurred on the date and hour stated above.

that I last saw her alive on May 13 1942

Immediate cause of death Toxic Adenoma Thyroid

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death).....

Major findings: Of operations Larg adenoma

Of autopsy.....

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) (c) Means of injury

Signature Edwin J. Hill (M. D. or other)

Address 462 N. Taylor Date signed

Duration

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.....

Albert G. Kappeler

Licensed Embalmer No.....

2974

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.