

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

1729

FILED MAR 9 1945

Registration District No.

818

Primary Registration District No.

1003

Registrar's No.

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(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 1 Day  
(Specify whether  
In this community 4 YEARS  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3674 McRee Ave  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Annice R. Newborn

3. (b) If veteran,

name war \_\_\_\_\_

3. (c) Social Security

No. \_\_\_\_\_

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

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

7. Birth date of deceased January 26 1881  
(Month) (Day) (Year)

8. AGE: Years 64 Months 0 Days 24 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Green Castle Indiana  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business at home

12. Name John W. Moore

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

14. Maiden name Anna Duncan

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

16. (a) Informant Mrs. Eleanor Craig Daughter

(b) Address 3674 Mc Ree Ave

17. (a) Removal (b) Date thereof Feb 22 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Castle Indiana

18. (a) Signature of funeral director Petz Bros

(b) Address 3029 Lafayette Ave

19. (a) FEB 21 1945 (b) J. F. Bredek  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 20th  
year 1945 hour 12:20 minute 18 M.

21. I hereby certify that I attended the deceased from 2/17/45  
to 2/19 1945  
that I last saw her alive on 2/19 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration 2 days  
Due to 74a

Other conditions Symptomatic Tuberculosis

Major findings: Of operations none Of autopsy none  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) na  
(b) Date of occurrence none  
(c) Where did injury occur? none  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
none  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Prison C. Hall (M. D. or other) MD  
Address 3402a Lafayette Date signed 2/20/45

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

**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 Frank J. Duran

Licensed Embalmer No. 2245

P. O. Address St. Louis, Mo.

**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.**