

S. No. 2  
M-5-43  
7. 5-17-39  
I X36571

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **17949**  
Registrar's No. **10940**

Registration District No. **317** Primary Registration District No. **2069**

1. PLACE OF DEATH  
(a) County **St. Louis**  
(b) City or town **Richmond Heights**  
(c) Name of hospital or institution: **St. Marys Hospital**  
(d) Length of stay: In hospital or institution (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo** (b) County **St. Louis**  
(c) City or town **St. Louis**  
(d) Street No. **3930 N. 25th St.**  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME **Ardell P. Newell**  
3. (b) If veteran **World War #2** name was  
3. (c) Social Security No.

4. Sex **Male** 5. Color of race **W**  
6. (a) Single, widowed, married, divorced **Single**  
6. (c) Age of husband or wife if alive years

7. Birth date of deceased **February 28 1925**  
(Month) (Day) (Year)

8. AGE: Years **21** Months **2** Days **13**  
If less than one day hr. min.

9. Birthplace **Darbury Iowa**  
(City or town) (State or foreign country)

10. Usual occupation **Student**  
11. Industry or business  
12. Name of father **Clarence L. Newell**  
13. Birthplace **Lyon Nebraska**  
14. Maiden name **Clara M. Kellogg**  
15. Birthplace **Des Moines Iowa**

16. (a) Informant **Dr. F. Newell**  
(b) Address **3930 N. 25th St.**

17. (a) Burial **Calvary** (b) Date thereof **5-14-46**  
(City or town) (State) (Month) (Day) (Year)  
(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **Stuart**  
(b) Address **225 Union Blvd.**  
19. (a) **5-14-46** (b) **E. M. D. ...**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **May** day **11**  
year **1946** hour **6:30** minute **9** A. M.  
21. I hereby certify that I attended the deceased from **March 25**  
19 **46** to **May 11** 19 **46**  
that I last saw him alive on **May 10** 19 **46**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Brain central Hemorrhage - left center**  
Due to **Prefrontal Lobotomy Operation** 5/7/46  
Due to **Schizophrenia - Heberline type** 3/25/46  
Other conditions (Include pregnancy within 3 months of death)

Major findings: **Prefrontal lobotomy 5/7/46**  
Of operations  
Of autopsy **Brain central Hemorrhage left**  
**Bleeding into ventricles**

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 **Matt ...** (M. D. or other) **M.D.**  
Address **6376 Eloy Road** Date signed **5/13/46**

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

16828

JUN 6 1946

JUN 28 1946

000-11021  
A. N. Walter Moore  
M. Club Bldg. Bld.  
6376 E. Dayton Rd.

STATEMENT BY LICENSED EMBALMER

AUG 28 1946

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.....

*E. W. Wilkins*

Licensed Embalmer No. 3575

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.