

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

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3908

FEDERAL SECURITY AGENCY

National Office of Vital Statistics

FILED OCT 9 1948

Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31308

Registrar's No. 8579

Primary Registration District No. 1003

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: Barnes Hospital, 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 DAYS (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County 999
(c) City or town Jasper (If outside city or town limits, write "RURAL") 11
(d) Street No. NR, (If rural, give location) Rural
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MILLARD E. NEWLIN

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 0 5. Color or race White 6. (a) Single, widowed, married, divorced Single 0

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

7. Birth date of deceased October 3 1897
(Month) (Day) (Year)

8. AGE: Years 50 Months 11 Days 26 If less than one day hr. _____ min. _____

9. Birthplace Jasper Co. Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Farmers

11. Industry or business _____

12. Name Charles Newlin

13. Birthplace Jasper Co. Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Alta Neeley

15. Birthplace Crawford Co. Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Frank Newlin
(b) Address Oblong, Ill.

17. (a) Removal (b) Date thereof 9-30-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oblong, Ill.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) OCT 1 1948 (b) J. F. Brueck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPTEMBER day 29
year 1948 hour 2 minute 25 A. M.

21. I hereby certify that I attended the deceased from SEPTEMBER 25
19 48 to SEPTEMBER 29 19 48
that I last saw him IM alive on SEPTEMBER 29 19 48
and that death occurred on the date and hour stated above.

Immediate cause of death RESPIRATORY FAILURE

Due to BRAIN TUMOR, MALIGNANT

Due to _____

Other conditions 54
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy NONE PERFORMED

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. F. Brueck (M. D. or other)

Address Barnes Hospital, Date signed 9/29/48

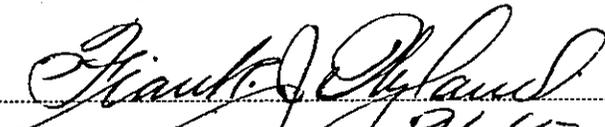
STATEMENT BY LICENSED EMBALMER

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..... 2645

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.