

FILED JUN 27 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

21495

State File No. \_\_\_\_\_

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>5168</b>			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE <b>Missouri</b>				b. COUNTY <b>Adair</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) <b>0</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		17 9 1			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Anthonys Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>4928 West Pine</b>				0	
3. NAME OF DECEASED (Type or Print) a. (First) <b>Ida</b>			b. (Middle) <b>E.</b>			c. (Last) <b>Newell</b>			
4. DATE OF DEATH (Month) (Day) (Year) <b>6 14 1949</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>Feb. 14, 1863</b>	
9. AGE (In years last birthday) <b>86</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 2 HRS. Hours _____ Min. _____		11. BIRTHPLACE (State or foreign country) <b>St. Louis, Missouri</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY _____			12. CITIZEN OF WHAT COUNTRY? <b>0</b>			
13a. FATHER'S NAME <b>Anton Rotty</b>			13b. MOTHER'S MAIDEN NAME <b>Barbara Renz</b>			14. NAME OF HUSBAND OR WIFE <b>James P. Newell</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>James E. Newell</b>				ADDRESS <b>4928 West Pine</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Vascular Disease</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>General Arteriosclerosis</b> DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Carcinoma of bladder</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>  <b>10 yrs.</b>  <b>6 wks</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <b>no operation</b>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) <b>97</b>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____			
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>4570</b>							
22. I hereby certify that I attended the deceased from <b>June 5, 1949</b> , to <b>6-14-49</b> , that I last saw the deceased alive on <b>6-13-49</b> , and that death occurred at <b>7:45 a.m.</b> , from the causes and on the date stated above.									
23a. SIGNATURE <b>R.V. Pearce</b> (Degree or title) <b>Dr. M.D.</b>				23b. ADDRESS <b>3720 Washington</b>			23c. DATE SIGNED <b>6-14-49</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>6-17-1949</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Missouri</b>			
DATE REC'D BY LOCAL REG. <b>1949</b>		REGISTRAR'S SIGNATURE <b>J. B. Lasater</b>			25. FUNERAL DIRECTOR'S SIGNATURE <b>Weick Bro. Und. Co.</b> ADDRESS <b>2201 S. Grand Bl</b>				

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

W. A. D. [unclear]  
3720 Washington

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed James L. Dunn  
Licensed Embalmer No. 4527

Signed \_\_\_\_\_  
Student Embalmer

P. O. Address 2201 S Grand Bl

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.