

FILED NOV 2 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35450

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9150

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		STREET ADDRESS (If rural, give location) 1221 N 14th St	

3. NAME OF DECEASED (Type or Print) a. (First) Beatrice		b. (Middle)		c. (Last) Newell		4. DATE OF DEATH (Month) (Day) (Year) Oct. 14 1951	
5. SEX 3 Female	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Jan 15 1878		9. AGE (In years last birthday) 73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Louisiana		12. CITIZEN OF WHAT COUNTRY? U S A	

13a. FATHER'S NAME John McGallion		13b. MOTHER'S MAIDEN NAME Frances Banks		14. NAME OF HUSBAND OR WIFE Dead	
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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 ADDRESS Rev. W. J. William 3517 Easton	
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Undet.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Undetermined DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Probable Bronchogenic Carcinoma Atelectasis right Lung		Undet.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 002XH

22. I hereby certify that I attended the deceased from 9-21, 19 51, to 10-14, 19 51, that I last saw the deceased alive on 10-14, 19 51, and that death occurred at 9:17 p m., from the causes and on the date stated above.

23a. SIGNATURE Herman J. Smith M. D.	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 10-15-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10/18/51	24c. NAME OF CEMETERY OR CREMATORY Washington Park	24d. LOCATION (City, town, or county) (State) St. Louis County Mo
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DATE REC'D BY LOCAL REG. OCT 17 1951	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Herman J. Smith 4247/w Labadie Ave
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WRITE PLAINLY—USING 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.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *Artemus Edwoodson*

Licensed Embalmer No. *341*

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.