THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 19730

FILED JUN 10 1953

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5348

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

1. PLACE OF DEATH
a. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Homer G Phillips Hospital 2229

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis

d. STREET ADDRESS (If rural, give location): 2825 Hickory

3. NAME OF DECEASED (Type or Print)
a. (First): T. J.
b. (Middle):
c. (Last): Newsom

4. DATE OF DEATH (Month) (Day) (Year): May 25 1953

5. SEX: Male 2

6. COLOR OR RACE: Col

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Dec. 31-1906

9. AGE (In years last birthday): 46 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: ?

11. BIRTHPLACE (State or foreign country): Ark

12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME: Not Known

13b. MOTHER'S MAIDEN NAME: Littie Botley

14. NAME OF HUSBAND OR WIFE: Leaner Newsom

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

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertension — INTERVAL BETWEEN ONSET AND DEATH: Undet.

ANTECEDENT CAUSES

Morbid 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. None

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

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) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? 443X

22. *I hereby certify that I attended the deceased from* 5-19, 1953, *to* 5-25, 1953 *that I last saw the deceased alive on* 5-25, 1953 *and that death occurred at* 8:15p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Edna E. Brooks M. D.

23b. ADDRESS: 2601 N Whittier St

23c. DATE SIGNED: 5-27-53

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal

24b. DATE: May 28-53

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) (State): Bald Knob, Ark.

DATE REC'D BY LOCAL REG.: MAY 28 1953

REGISTRAR'S SIGNATURE: J Carl Smith MD MJB

25. FUNERAL DIRECTOR'S SIGNATURE: S J Watson 2769

ADDRESS: Montcalm

(Licensed Embalmer's Statement on Reverse Side)

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 S J Watson

Licensed Embalmer No. 249

P. O. Address 2769 Chrute

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.