

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **10306**

BIRTH NO. **FILED MAR 19 1954** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1997**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Mo.		a. STATE Missouri. b. COUNTY	
c. CITY OR TOWN St. Louis,		d. In Residence within limits of a city, town, or unincorporated town?	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis, City Hosp.		e. STREET ADDRESS (If rural, give location) 4347 West Pine.	

3. NAME OF DECEASED a. (First) Harvey b. (Middle) D. c. (Last) Newkirk		4. DATE OF DEATH (Month) (Day) (Year) Mar. 1, 1954.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, SEPARATED. (Specify)	8. DATE OF BIRTH Dec. 23, 1906.
9. AGE (In years less birthday) 47.	# UNDER 1 YEAR Months Days	# UNDER 100 HRS. Hours Min.	
10a. MAJOR OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator	10b. KIND OF BUSINESS OR INDUSTRY Genl. Cable Co.	11. BIRTHPLACE (City and State or Foreign Country) Naylor, Missouri.	12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Simon Newkirk	13b. MOTHER'S MAIDEN NAME Sylvia Smoot	14. NAME OF HUSBAND OR WIFE Nellie Newkirk.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) No. Nil.	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Nellie Newkirk, 915 Chouteau, (Aunt)
		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, asphyxia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Coronary Thrombosis</i> DUE TO (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)
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? 4201

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at *11:20 A.M.*, from the causes and on the date stated above.

23. SIGNATURE <i>Patrick P. Taylor</i> (Degree or title) Coroner	23b. ADDRESS 1300 Clair	23c. DATE SIGNED 3. 3. 54
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 3-2-54	24c. NAME OF CEMETERY OR CREMATORY Antioch Cemetery
24d. LOCATION (City, town, or county) (State) Naylor, Missouri.		

DATE REC'D BY LOCAL REG. MAR 3 1954	REGISTRAR'S SIGNATURE <i>J. Earl Smith</i>	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe, 4700 Washington Blvd
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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.....
Signature of Student Embalmer

Signed *Robert M. Murray*.....

3749
Licensed Embalmer No.

P. O. Address *St. Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.