THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED FEB 21 1957

6500

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 378

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes X No ☐	c. CITY OR TOWN Clayton, 5, 4452 — Inside Limits Yes X No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Missouri Baptist Hospital — Length of stay in 1b 16	d. STREET ADDRESS (If outside, give location) 39 Crestwood Drive 27 — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print)	First: BERT	Middle:	Last: NEWBURGER
4. DATE OF DEATH	Month: January	Day: 13th	Year: 1957
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: September 28, 1884
9. AGE (In years last birthday): 72	IF UNDER 1 YEAR: Months 3 Days 15	IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired President - General Grocer Company	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country): Louisville, Kentucky	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Joseph Newburger		14. MOTHER'S MAIDEN NAME: Katherine Sale	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -------	16. SOCIAL SECURITY NO.: 494-10-3053	17. INFORMANT: Mrs. Catherine B. Newburger — Address: 39 Crestwood Co.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 1 week

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Adeno-Carcinoma - Sigmoid

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension 153X

19. WAS AUTOPSY PERFORMED? YES ☐ NO X

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Oct 56, to Jan 13 and last saw her/him alive on 1-13-57. Death occurred at 10:25 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): [signature] M.D.	22b. ADDRESS: Carleton Bldg	22c. DATE SIGNED: 1-14-57	
23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation	23b. DATE: 1 / 16 / 57	23c. NAME OF CEMETERY OR CREMATORY: Oak Grove Crematory	23d. LOCATION (City, town, or county) (State): St. Louis County, Missouri
24. FUNERAL DIRECTOR: C. R. Lupton & Sons — ADDRESS: 7233 Delmar Blvd.	25. DATE RECD. BY LOCAL REG.: JAN 14 '57	26. REGISTRAR'S SIGNATURE: J Earl Smith MD MGB	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

Res: 12-2-1-4-0

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e

by me, or by ....., Student Embalmer No.....

working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed Arnold W. Schoen

Licensed Embalmer No. 38

P. O. Address St. Lou

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.