

FILED OCT 22 1957

## STANDARD CERTIFICATE OF DEATH

State File No. **37053**

BIRTH NO. _____		REG. DIST. NO. <b>306</b>		PRIMARY REG. DIST. NO. <b>6048</b>		Registrar's No. <b>24</b>	
1. PLACE OF DEATH a. COUNTY <b>St. Charles</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) <b>O'Fallon</b>		c. LENGTH OF STAY (in this place) <b>3 weeks</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Roeper Nursing Home</b>				d. STREET ADDRESS (If rural, give location) <b>4332 Mc Ree</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Della</b>		b. (Middle) <b>A.</b>		c. (Last) <b>Newton</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 16 1957</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>		8. DATE OF BIRTH <b>April 6 1885</b>		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 1 MONTH IF UNDER 1 HOUR IF UNDER 1 MIN. <b>72</b> Months Days Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Not known</b>			13b. MOTHER'S MAIDEN NAME <b>Wagner</b>		14. NAME OF HUSBAND OR WIFE <b>John Newton</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Roeper Nursing Home O'Fallon Mo.</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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Occlusion</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>arteriosclerosis</b>  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? <b>2</b> 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>4201</b>			
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?			
22. I hereby certify that I attended the deceased from <u>Oct 10</u> , 1957, to <u>Oct 16</u> , 1957, that I last saw the deceased alive on <u>Oct 16</u> , 1957, and that death occurred at <u>7:45 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Harold C. Mangold, D.O.</b>				23b. ADDRESS <b>O'Fallon Mo</b>		23c. DATE SIGNED <b>10-19-57</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Oct. 19 57</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>Oct. 19 1957</b>		REGISTRAR'S SIGNATURE <b>E. K. Keithy</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Beiderwieden St. Louis Mo.</b>			

(Licensed Embalmer's Statement on Reverse Side)

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

OCT 28 1957

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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

*E. E. Keithly*

Licensed Embalmer No. 822

P. O. Address Fallon 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.