

58-008411

STATE FILE NUMBER

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED MAR 5 - 1958

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 493

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Manchester</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Manchester Nursing Home</b>		Length of stay in 1b <b>1 Month</b>	d. STREET ADDRESS <b>4332 McFee</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>C.</b> Last <b>Newton</b>		4. DATE OF DEATH Month <b>February</b> Day <b>14,</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1874</b> <b>February 8, 1958</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Yard Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Alton Brick Co.</b>	11. BIRTHPLACE (City and state or country) <b>Campbell Hill, Ill.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		14. NAME OF HUSBAND OR WIFE <b>Della L. Wagner Newton</b>	
13a. FATHER'S NAME <b>John Wesley Newton</b>		13b. MOTHER'S MAIDEN NAME <b>Sophonria Carter</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>494-07-7925</b>	17. INFORMANT <b>Mrs. Opal Vaughn</b> Address <b>4332 McFee Ave</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac De-compensation</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Heart Block</b>			<b>Don't know</b>
DUE TO (c) <b>Arteriosclerosis</b>			<b>433.0</b> <b>Don't know</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Coronary Hypertrophy, Prostatism</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		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.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <b>Jan. 26th, 1958</b> , to <b>Feb. 14, 58</b> and last saw her alive on <b>Feb. 14th, 58</b> Death occurred at <b>6:25 P. M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Kathleen Kaffey</b> (Degree or title)		22b. ADDRESS <b>Manchester Car Rd. #141</b> <b>Manchester, Mo.</b>	
22c. DATE SIGNED <b>2-17-58</b>			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE <b>Febr. 18, 58</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>	
24. FUNERAL DIRECTOR <b>Beiderwieden F.H. Inc. 1936 St. Louis Ave.</b>		25. DATE RECD. BY LOCAL REG. <b>2-17-58</b>	
26. REGISTRAR'S SIGNATURE <b>Deibert R. Donke MD</b>			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATE

3-10-58

All diseases in Part I must be causally related.

Health, Welfare  
Public Service300  
-57

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MAR 10 1958

6-8 -  
Corner N. 141 + Main Streets  
R.L.  
9-12 2-4

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  \_\_\_\_\_

Licensed Embalmer No. 4520  
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.