

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-042769

STATE FILE NUMBER

FILED DEC 10 1958

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 3174

300  
1-57

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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>St. Louis</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Valley Park</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Shewsberry</b> <u>4564</u>		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>Moll Nursing Home</b>		Length of stay in lb <b>2 years</b>	d. STREET ADDRESS (If outside, give location) <b>7725 Suffolk Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MAMIE</b> Middle <b>L.</b> Last <b>NEWSOM</b>			4. DATE OF DEATH Month <b>12</b> Day <b>2</b> Year <b>58</b>		
5. SEX <b>Female</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>1-18-77</b>	9. AGE (In years last birthday) <b>81</b> IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	11. BIRTHPLACE (City and state or country) <b>Calhoun County, Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Arnold Smith</b>		13b. MOTHER'S MAIDEN NAME <b>Balden</b>		14. NAME OF HUSBAND OR WIFE <b>John H. Newsom</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> <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Mrs. R. M. Schroedel Shewsberry, Mo.</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) <u>Coronary Occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>4201</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>4 yrs</u>
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 <input type="checkbox"/> Month, Day, Year a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>					
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 <u>11/9/56</u> to <u>12-2-58</u> and last saw her <sup>her</sup> <sub>him</sub> alive on <u>12/2/58</u> Death occurred at <u>2:30 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>[Signature]</u> (Deputy or title)			22b. ADDRESS <u>Kirkwood 21 Mo.</u>		22c. DATE SIGNED <u>12/4/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-5-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, County, Mo.</b>
24. FUNERAL DIRECTOR <b>White-Mullen 118 N. Florissant Rd.</b>		25. DATE RECD. BY LOCAL REG. <b>12-4-58</b>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

Do not write symptoms which are related.

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 *Eleazar Poince* .....

Licensed Embalmer No. *3403* .....

P. O. Address *Jennings, 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.