

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011238
STATE FILE NUMBER
2640

HEALTH, Welfare, Public Service
FILED APR 6 1959 Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Overland 424X</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 <u>Jewish Hosp</u>		Length of stay in lb <u>3 da</u>	d. STREET ADDRESS (If outside, give location) <u>2909^c Lyndhurst</u> Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLIFFORD ALFRED NEWBY</u>			4. DATE OF DEATH Month Day Year <u>MAR 14, 1959</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/8/04</u>
9. AGE (In years last birthday) <u>54</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Photo Engraver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Post Dispatch</u>	11. BIRTHPLACE (City and state or country) <u>Norwood Ohio</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>William W Newby</u>	
13b. MOTHER'S MAIDEN NAME <u>Amelia Bornholz</u>		14. NAME OF HUSBAND OR WIFE <u>Helen Newby</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>490-01-1836</u>	17. INFORMANT Address <u>Helen Newby Overland Mo</u>
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>MYOCARDIAL INFARCTION</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>CORONARY ARTERIOSCLEROSIS</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
DUE TO (c) <u>420.1</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>BRONCHIAL ASTHMA</u>			
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK 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 <u>Dec. '58</u> to <u>MAR '59</u> and last saw <u>him</u> alive on <u>14 MAR. '59</u> Death occurred at <u>10:35</u> P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Robert S. Karsh, M.D.</u>		22b. ADDRESS <u>2560a Woodson</u>	22c. DATE SIGNED <u>14 Mar '59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>3/18/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Lebanon</u>	23d. LOCATION (City, town, or county) (State) <u>Bridgeton Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Ortmann F Home 9222 Lackland</u> <u>Overland Mo</u>		25. DATE RECD. BY LOCAL REG. <u>MAR 16 '59</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u> <u>E.P.</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms or signs of disease in Part I must be causally related.

300
-57
150
+X

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 Samuel Stipanovic, Student Embalmer No. 578 working under my personal supervision.

Student

Samuel Stipanovic
Signature of Student Embalmer

Signed

A. C. Artmann

Licensed Embalmer No. 3478

P. O. Address.....

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.