

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015488

STATE FILE NUMBER

Registration District No. Primary Registration District No. Registration No. 3296

FILED APR 20 1959

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i> | | b. COUNTY <i>Missouri</i> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>5103 - Jerry</i> | | c. CITY OR TOWN <i>St. Louis</i> | |
| Length of stay in lb | | d. STREET ADDRESS <i>5103 - Jerry</i> | |
| | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|--|------------------------------------|---|---|---|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>Michel Glenn Newson</i> | | | 4. DATE OF DEATH Month Day Year <i>April 1 1959</i> | | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>Colored</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Dec 31, 1928</i> | 9. AGE (In years last birthday) <i>3</i> | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>None</i> | 11. BIRTHPLACE (City and state or country) <i>St. Louis Mo</i> | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13a. FATHER'S NAME | | 13b. MOTHER'S MAIDEN NAME <i>Ernestine Newson</i> | 14. NAME OF HUSBAND OR WIFE | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no) (If yes, give war or dates of service) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>none</i> | 17. INFORMANT <i>Ernestine Newson 5103 Jerry</i> | | |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Interstitial Pneumonia</i> | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |

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| 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.) <i>525X</i> | |
| 20c. TIME OF INJURY Hour Month, Day, Year 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 *8:55 A.M.* to _____ and last saw her/him alive on _____
Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <i>Joseph M. Quinn</i> | 22b. ADDRESS <i>1200 Clark</i> | 22c. DATE SIGNED <i>4/2/59</i> |
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|--|-----------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>4-2-59</i> | 23b. DATE | 23c. NAME OF FERRY OR CREMATORY <i>Father Jackson St. Louis Co. Mo.</i> | 23d. LOCATION (City, town, or county) (State) |
|--|-----------|--|---|

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| 24. FUNERAL DIRECTOR <i>Mrs. S. J. Peters 276 Chestnut</i> | 25. DATE RECD. BY LOCAL REG. <i>APR 2 '59</i> | 26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i> |
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally 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 *not embled*
Helena Vespa

Licensed Embalmer No.....
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.