

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-013019

FILED VS MAR 3 1 1960

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STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Massachusetts</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Length of stay in 1b <i>1 year</i>	c. CITY OR TOWN <i>St. Louis</i>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>4964 Kennerly Ave.</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>4964 Kennerly Ave.</i>
3. NAME OF DECEASED (Type or print) First <i>Luella</i> Middle <i>M.</i> Last <i>Newton</i>		4. DATE OF DEATH Month <i>March</i> Day <i>19</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</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>4/23/1882</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Supv. of Home Interiors</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <i>77</i>
11. BIRTHPLACE (City and state or country) <i>Eldred Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY <i>USA.</i>	
13a. FATHER'S NAME <i>William Spencer Newton</i>		13b. MOTHER'S MAIDEN NAME <i>Jennie Elizabeth Seeley</i>	13c. NAME OF HUSBAND OR WIFE <i>Single</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>N/D</i>		16. SOCIAL SECURITY NO. <i>490-38-8998</i>	17. INFORMANT <i>Lera M. Jones 4964 Kennerly Ave.</i>
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>Cerebral arteriosclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)			
DUE TO (c) <i>334x</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Degenerative heart disease, compensated</i>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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 <i></i> a.m. <i></i> p.m. <i></i> Month, Day, Year <i></i>			
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 <i>1956</i> to <i>present</i> and last saw her alive on <i>3-16-60</i> Death occurred at <i>about 11</i> <i>A.M.</i> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Dr. Max Well M.D.</i>		22b. ADDRESS <i>4500 Olive St</i>	22c. DATE SIGNED <i>3-21-60</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>March 22/60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St. Matthew Cem</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis Mo.</i>
24. FUNERAL DIRECTOR <i>Sue Campbell</i>		25. DATE RECD. BY LOCAL REG. <i>MAR 21 1960</i>	26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*J. W. Binkley*

Licensed Embalmer No. 3653

P. O. Address H. Lee S

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.