

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1716

FEB 26 1927

1. PLACE OF DEATH

County..... Linn
Township..... Laclede
City..... Laclede

Registration District No. 540
Primary Registration District No. 4803

File No.
Registered No. 1
St. Ward)

2. FULL NAME

(a) Residence. No. Latina Jones Newley St. Ward.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 36 yrs. - mos. - ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W - 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Samuel G. Newley

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 21 - 1841

7. AGE 85 YEARS 11 MONTHS 10 DAYS If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) Laceyburg (STATE OR COUNTRY) Virginia

10. NAME OF FATHER Joseph Dodd

11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY).....

12. MAIDEN NAME OF MOTHER Sarah Jordan

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY).....

14. INFORMANT Newley Osgood (Address) Brookfield, Mo.

15. FILED 11/31 19 27 J. J. Bush REGISTRAR

1 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 31 1927

17. I HEREBY CERTIFY, That I attended deceased from Jan 27, 1927 to Jan 31, 1927 that I first saw h. ex. alive on Jan 27, 1927, and that death occurred, on the date stated above, at 5:00 P.M. in.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral embolism
824 7/401 (duration) yrs. mos. ds. 4 ds.

CONTRIBUTORY (SECONDARY)..... (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED X IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no DATE OF 4

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Symptoms
(Signed) J. N. Thorne M. D.
Jan 31, 1927 (Address) 1317 1/2 Laclede

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Laclede, Mo. DATE OF BURIAL Feb 4 1927

20. UNDERTAKER W. E. Thorne ADDRESS Laclede

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

