

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

Do not use this space.

6505

1. PLACE OF DEATH

County Jackson Registration District No. \_\_\_\_\_  
Township Kan Primary Registration District No. \_\_\_\_\_  
City Kansas City Mo (No. Wesley Hts) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. 638  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

Rudolph Newman  
(a) Residence, No. 9526 Winner Rd. St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred 48 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Annie M. Newman

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 8 - 1846

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
82 4 1

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Retired  
(b) General nature of industry, business, or establishment in which employed (or employer) Tailor  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Bastenstern  
(STATE OR COUNTRY) Germany

10. NAME OF FATHER John Newman

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

12. MAIDEN NAME OF MOTHER not known

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

14. INFORMANT Richard E. Newman  
(Address) 9526 Winner Rd

15. FILED 2/9/29 J. M. Lane REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 9 - 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb 8, 1929, to Feb 29, 1929  
that I last saw him alive on 2 - 14 29, 1929, and that death occurred, on the date stated above, at 1457th m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Obstruction Intestines

CONTRIBUTORY (SECONDARY) Jymotomny  
(duration) \_\_\_\_\_ yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED None  
IF NOT AT PLACE OF DEATH: \_\_\_\_\_

1 DID AN OPERATION PRECEDE DEATH: yes A DATE OF Feb - 8 - 1929

WAS THERE AN AUTOPSY? No  
WHAT TEST CONFIRMED DIAGNOSIS? Stethal vomiting  
(Signed) R. P. Miller M. D.  
7/9, 1929 (Address) 801 Market Bldg.

\*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 401 Washington Cem DATE OF BURIAL Feb 11 - 1929

20. UNDERTAKER John W Wagner ADDRESS 1409 Grand Ave

89-40

REPORT 21 APR 1954

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County..... Registration District No. 399  
 Township..... Primary Registration District No. 1002  
 City St. Louis (No. ....) St. .... Ward)

**2. FULL NAME**

(a) Residence. No. .... St. .... Ward. ....  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 9 19 29

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

17. I HEREBY CERTIFY That I attended deceased from ..... 19..... to ..... 19....., that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at..... m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

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

Obstruction Prostate  
caused by Cancer  
of Prostate  
..... (duration) yrs. mos. ds.

8. OCCUPATION OF DECEASED

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

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

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

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

10. NAME OF FATHER

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

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

WAS THERE AN AUTOPSY? .....

12. MAIDEN NAME OF MOTHER

WHAT TEST CONFIRMED DIAGNOSIS.....

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

(Signed) R. P. Miller, M. D.  
..... 19 (Address)

14. INFORMANT..... (Address)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

15. FILED 7/9 29 M. M. Coroue REGISTRAR  
Asst

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL... A E FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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