

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

Do not use this space.

1420

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City

Registration District No. 399
Primary Registration District No. 10
(No. 3660 Summit)

File No. 412
Registered No. 412
St. _____ Ward _____

2. FULL NAME

Oscar Newlee

(a) Residence. No. Liberty Mo St. _____ Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 10 1914

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>About 65</u>			<u>18</u>	

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).
(c) Name of employer

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

10. NAME OF FATHER Chas A. Newlee

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

12. MAIDEN NAME OF MOTHER Mary C Huff

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

14. INFORMANT Coroner's Record
(Address) Kansas City Mo

15. FILED 1/28 30 1930 M. M. Crowe
REGISTRAR ansr

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 28 1930

17. I HEREBY CERTIFY, That Deputy Coroner 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.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

suicide, cut throat with razor

CONTRIBUTORY (SECONDARY) 17 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH _____ DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS History & Inspection

(Signed) Stanley M. Hall, M. D.

1/28 1930 (Address) Deputy Coroner
*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 Liberty, Mo. **DATE OF BURIAL** Jan. 30, 19 30

20. UNDERTAKER R. V. Lindsey & Sons, Inc **ADDRESS** City Kansas Mo

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.

262
2

