

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

33704

**1. PLACE OF DEATH**

County Buchanan  
Township St Joseph Mo  
City St Joseph Mo

Registration District No. 35  
Primary Registration District No. 1001  
State Hospital #2.

File No. \_\_\_\_\_  
Registered No. 1102  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. Independence, Mo.  
(Usual place of abode) (If non-resident, give city or town and State)  
Length of residence in city or town where death occurred yrs. 3 mos. 5 ds. How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 3, 1887

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
44 7 24

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Nurse  
(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) Linn Co. Iowa

10. NAME OF FATHER Johnson P. Newman

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

12. MAIDEN NAME OF MOTHER Mary E. Cliphart

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

14. INFORMANT (Address) State Hospital # 2 Bend St Joseph Mo

15. FILED 10-29, 1931 John R. Bender REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 27, 1931  
17. I HEREBY CERTIFY, That I attended deceased from July 22, 1931, to Oct 27, 1931, that I last saw him alive on Oct 27, 1931, and that death occurred, on the date stated above, at 1:30 pm.

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

Purpura  
Over (duration) yrs. 3 mos. 5 ds.

CONTRIBUTORY (SECONDARY) 83 (duration) yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED? Unknown  
IF NOT AT PLACE OF DEATH \_\_\_\_\_

0 DID AN OPERATION PRECEDE DEATH? No. DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Smear  
(Signed) Caliston Smith, M. D.

State Hosp # 2 Mo St Joseph Mo  
(Address) Oct 27 19 31

\*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 State Hospital Cemetery DATE OF BURIAL Oct, 29, 1931

20. UNDERTAKER Walter Meierhoffer ADDRESS 1302 Faraon St.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

NOV 29 1931

