

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.

GENUINE 1938

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

42353
Do not use this space.

1. PLACE OF DEATH

(a) County Buehman Registration District No. 85
(b) Township _____ Primary Registration District No. 1001 Registered No. 1231
(c) City St. Joseph (d) Street No. St. Joseph Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 1 yrs. 0 mos. 0 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

OCTAVIS - A - NEWKIRK
(a) Residence, No. 414 Woodson St. St. Mo.
(Usual place of abode, if no street address, write county or city) (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) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 29 1879

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
59 0 10

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. W. P. A., worker
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) Nov. 30 1938 11. Total time (years) spent in this occupation 2 mo

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pomona, Kans.

FATHER 13. NAME Thomas Newkirk

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Do not know Ill.

MOTHER 15. MAIDEN NAME Arinda Sharpless

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Do not know Ill.

17. INFORMANT (ADDRESS) Mrs. Carrie Newkirk St. Joseph Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Osage City, Kans. DATE Dec 11 38

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Stoney Funeral Home St. Joseph Mo.

20. FILED Dec 9 1938 W. J. Needlebach Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 9, 1938

22. I HEREBY CERTIFY, That I attended deceased from 12-8, 1938, to 12-9, 1938

I last saw him alive on 12-8, 1938. Death is said to have occurred on the date stated above, at 5:15 A.M.

The principal cause of death and related causes of importance were as follows:

Pneumonia & Pulmonary Edema

Date of onset 2 weeks

Other contributory causes of importance:

Name of operation no Date of X

What test confirmed diagnosis? X Ray Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify _____

(Signed) W. J. Needlebach, M. D.

(Address) St. Joseph Mo.

STATEMENT BY LICENSED EMBALMER

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

myself

or by

Raymond Atwood

Registered Apprentice No. *166*, working under my personal supervision.

Signed

John Roy Stacey

Licensed Embalmer No.

2435

P. O. Address

St. Joseph, Ill.

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 this body is not embalmed, above space should be left blank.

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

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

42353
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85
 (b) Township Primary Registration District No. 1001
 (c) City St. Joseph (d) Street No. St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Octavia A Newkirk

(a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
59 0 10

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

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

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OF COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 9 1938

22. I HEREBY CERTIFY, That I attended deceased from 19... to 19...

I last saw h... alive on..., 19... Death is said to have occurred on the date stated above, at... m.

The principal cause of death and related causes of importance were as follows:

Pneumonia Bronchitis
Pulmonary Oedema
 Other contributory causes of importance: 10/15

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury 19...

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Queen D. Craig, M. D.

(Address) St. Joseph

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENT

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