

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.

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

34968  
Do not use this space.

NOV 14 1939

1. PLACE OF DEATH  
(a) County JACKSON | Registration District No. 399  
(b) Township KAW | Primary Registration District No. 1002  
(c) City KANSAS City | (d) Street No. St. Joseph Hosp. Registered No. 3943  
(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 MRS. MARY GLADYS Newby.  
(a) Residence, No. 5245 Woodland St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe | 4. COLOR OR RACE Wh. | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) MAR-11-1892

7. AGE YEARS 47 | MONTHS 7 | DAYS 0 | If LESS than 1 day, hrs. or min.

OCCUPATION  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
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) KANSAS City KANSAS.

FATHER  
13. NAME John McCleery  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Louisville Kentucky

MOTHER  
15. MAIDEN NAME Katherine Wilson  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Louisville Kentucky

17. INFORMANT (ADDRESS) M. O. Newby 5245 Woodland.

18. BURIAL, CREMATION, OR REMOVAL PLACE CREMATION DATE Oct. 13, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wm. Newcomer Sons Pass + Brush Creek

20. FILED 10-12-39 19 M. M. Crowe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 11, 1939

22. HEREBY CERTIFY, That I attended deceased from May 1936 to Oct 1939. I last saw her alive on 10/11/39, 19. Death is said to have occurred on the date stated above, at 5:30 p. m. The principal cause of death and related causes of importance were as follows:  
Pulmonary Tuberculosis Date of onset 23

Other contributory causes of importance: None

Name of operation Thoracoplasty Date May 1936  
What test confirmed diagnosis? Sputum Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide None Date of injury, 19. Where did injury occur? None (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury None  
Nature of injury None

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify: None  
(Signed) W. M. Crowe, M. D. (Address) Kansas City, Mo.

Dr. Buckingham  
Room 802  
Prof. Bldg.  
Mrs. Newby

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**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, .....

....., or by .....

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

Signed..... *A. O. Newcomer Jr* .....

Licensed Embalmer No. *4043* .....

P. O. Address *Kansas City, Mo* .....

**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.**