

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10932

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(c) Name of hospital or institution St. Johns Hospital
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

3. (a) PRINT FULL NAME Jesse A. Newton
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex Male 5. Color or race White
6. (a) Single, married, divorced Married
6. (b) Name of husband or wife Bessie Newton
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May 14, 1880
(Month) (Day) (Year)

8. AGE: Years 59 Months 10 Days 17
 If less than one day _____ hr. _____ min.

9. Birthplace Manassas, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Heat metal worker

11. Industry or business Railroad

MOTHER: 12. Name John Newton
13. Birthplace Ky.
14. Maiden name Elyzabeth
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Bessie Newton

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof 4-3-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Haystack

18. (a) Signature of funeral director Alm. Schumacher
(b) Address Springfield, Mo.

19. (a) 4/15/40 (b) Chas. A. George, Jr.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Springfield
(d) Street No. 830 New Street
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 1
year 1940 hour 2 minute _____ A. M.

21. I hereby certify that I attended the deceased from March 3
1940, to April 1, 1940
that I last saw him alive on March 31, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis Duration 1 month

Due to _____
Due to _____

Other condition Influenza in January, 1940
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy no autopsy
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature E. L. Carver (M. D. certifying)
Address 318 Holland Bldg. Date signed 4-3-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Rev. 5-17-39
U.S. GPO

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

Wayne Finkle

Licensed Embalmer No.

3444

P. O. Address

Springfield 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.

X