

11 AUG 5 1940

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

26197  
Do not use this space.

1. PLACE OF DEATH 2

(a) County St. Genevieve Registration District No. 934

(b) Township Union Primary Registration District No. 100-2-4 Registered No. ....

(c) City ..... (d) Street No. .... (If death occurred in Hospital or Institution, write its name instead of street and number) St. ....

(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 Adam Roseae Newberger

(a) Residence, No. Farmington, R.F.D. # 4 (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 Florea Mae Newberger

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 1, 1893

7. AGE YEARS 47 MONTHS 6 DAYS 6 If LESS than 1 day, ..... hrs. or ..... min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. W.P.A.

9. Industry or business in which work was done, as saw mill, bank, etc. Government

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) Bonne Terre Missouri

13. NAME Adam Newberger

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

15. MAIDEN NAME Fanny Wigger

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

17. INFORMANT (ADDRESS) Florea Mae Newberger Farmington, Route 4

18. BURIAL, CREMATION, OR REMOVAL PLACE Sprath DATE July 9, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) C. Z. Boyer Desloge, Missouri

20. FILED July 9, 1940 Res. Joseph G. Kassner Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 7, 1940

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

I last saw him ..... alive on ....., 19 ..... Death is said to have occurred on the date stated above, at 2:10 A.M.

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

Cause of Death Pending Date of onset .....

Other contributory causes of importance: .....

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 Yes (Signed) Lucy Baskin Cooper M.D. (Address) St. Genevieve, Mo.

COPIED FROM ORIGINAL 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

S.S. 498-10-3163

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

*E. J. Boyer*

Licensed Embalmer No.

*1671*

P. O. Address

*Westgate 9*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure with the above constitutes grounds for revocation of license.)

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

NOV 18 1950

EMBALMERS' ASSOCIATION  
OF THE DISTRICT OF COLUMBIA  
1400 K STREET, N.W.  
WASHINGTON, D.C. 20004

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 26197

Registration District No. 934

Primary Registration District No. 6056

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County St Genevieve  
(b) City or town Paris  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In \_\_\_\_\_ community \_\_\_\_\_  
(Specify whether \_\_\_\_\_  
hrs, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County St Genevieve  
(c) City or town Paris  
(If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

PRINT FULL NAME Adam Rose Newberger  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month July day 7  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

7. Birth date of deceased: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_  
8. AGE: Years 47 Months 6 Days 6 If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min.

Due to chronic alcoholism  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

9. Birthplace: (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_  
10. Usual occupation \_\_\_\_\_

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
12. Name \_\_\_\_\_  
13. Birthplace: (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_  
14. Maiden name \_\_\_\_\_  
15. Birthplace: (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

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 \_\_\_\_\_

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_  
17. (a) \_\_\_\_\_ (b) Date thereof: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_  
(c) \_\_\_\_\_ (Burial, cremation, or removal) \_\_\_\_\_  
(d) \_\_\_\_\_ (Burial or cremation)

23. Signature Lee C. Bash \_\_\_\_\_ M. D. or other \_\_\_\_\_  
Address St. Genevieve Mo \_\_\_\_\_ Date signed 9/15/44

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_  
19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Designated local registrar) (Registrar's signature)

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

COPY UNFADING BLACK INK—MAKE A PERMANENT RECORD

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **26197**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **934**

Primary Registration District No. **60 SL (6026)**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County **St. Genevieve**  
(b) City or town **Sumner**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ (Specify whether)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **St. Genevieve**  
(c) City or town **rural**  
(If outside city or town limits write "RURAL")  
(d) Street No. **Farmington RFD #4**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME

**Adam Rose Newberger**

3. (b) If veteran, name war

3. (c) Social Security No.

**Newberger**

19. MEDICAL CERTIFICATION

20. DATE OF DEATH Month **July** day **7**  
year **1940** hour **2** minute **10 A.M.**  
21. I hereby certify that I attended the deceased from \_\_\_\_\_  
\_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex

**m**

5. Color or race

**w**  
6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife

**Flora Mae Newberger**

6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased

**January 1<sup>st</sup> 1893**  
(Month) (Day) (Year)

22. I hereby certify that I attended the deceased from \_\_\_\_\_  
\_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

8. AGE:

Years **47** Months **6** Days **6**  
If less than one day \_\_\_\_\_ min.

Immediate cause of death **Cause - Pending Finding of examination of viscera**

9. Birthplace

**Bonne Terre Mo**  
(City, town, or county) (State or foreign country)

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

10. Usual occupation

**WPA member**

Other conditions (Include pregnancy within 3 months of death)

MOTHER FATHER

11. Industry or business

**Adam Newberger**

12. Name

**mo** (City, town, or county) (State or foreign country)

13. Birthplace

**Farmington Mo** (City, town, or county) (State or foreign country)

14. Maiden name

**Fanny Wigger** (City, town, or county) (State or foreign country)

15. Birthplace

**mo** (City, town, or county) (State or foreign country)

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant

**Flora Mae Newberger**

(b) Address

**Farmington RFD #4**

17. (a) (b) Date thereof

**July 9 Burial** (Month) (Day) (Year)

(c) Place: burial or cremation

**Spiroff mo**

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? \_\_\_\_\_

18. (a) Signature of funeral director

**C. J. Boyer**

(b) Address

**212 1/2 W. 10th St. mo**

19. (a) (b) Date received local registrar

**July 9 - 1940** (Month) (Day) (Year)

(c) Registrar's signature

**Rev Joseph J. Tassner** (Registrar's signature)

While at work? \_\_\_\_\_

(Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature

**Leo C Barber Coroner** (M. D. or other)

Address

**St. Genevieve Mo** Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

A

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 26197

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 934

Primary Registration District No. 6036

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH

(a) County St. Genevieve  
(b) City or town Union  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether

In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME

Adam Roscoe Newberger

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
47 6 6 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 7 year 1996 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Cause of death

Pending

Due to acute alcoholism

Due to Cerebral Hem. of 7:10

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTAL