

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.

Registration District No. 821

Primary Registration District No. 2553

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Scott
 (b) City or town Sikeston
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 2
 (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 Ellen Newton 350
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

4. Sex F 5. Color or race W
 6. (a) Single, widowed, married, divorced M
 6. (b) Name of husband or wife Elbert G. Newton
 6. (c) Age of husband or wife if alive 39 years
 7. Birth date of deceased 10 9 95
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
44 9 12 _____ hr. _____ min.

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

10. Usual occupation housework

11. Industry or business _____

MOTHER FATHER { 12. Name Bill Messner
 13. Birthplace Unknown 9
 (City, town, or county) (State or foreign country)

{ 14. Maiden name Mary 9
 15. Birthplace ? _____
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Soble Newton
 (b) Address Sikeston Mo.

17. (a) Burial (b) Date thereof 7/22/40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Sikeston Mo.

18. (a) Signature of funeral director John Newton 742
 (b) Address Sikeston Mo.
 (Specify type of place) _____

19. (a) 8-6-40 (b) [Signature]
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Scott
 (c) City or town Sikeston
 (If outside city or town limits, write "RURAL")
 (d) Street No. 419 Williams
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 21
 year 1940 hour 3 minute 45 a.m.

21. I hereby certify that I attended the deceased from July 21, 1940, to July 21, 1940,
 that I last saw her alive on July 31, 1940,
 and that death occurred on the date and hour stated above.

Immediate cause of death Heart failure (Myocarditis) Duration _____
 Due to Coronary Occlusion

Due to _____
 Other conditions 438
 (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? _____

23. Signature [Signature] (M. D. or other) _____
 Address [Address] Date signed July 25

RECEIVED

District Health Officer No. 2

District File Number 840-1316

Date Filed 8/7/40

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 me

was Embalmed, Registered Apprentice No. _____
working under my personal supervision.

Signed

John A. Sutton

Licensed Embalmer No. 2941

P. O. Address Like to A

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.