

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

Do not use this space.

OCT 12 1940

31634

**1. PLACE OF DEATH**

County Cape  
Township  
City Cape Girardeau (No. ....)

Registration District No. 125  
Primary Registration District No. 3009

File No. ....  
Registered No. 334  
St. .... Ward)

**2. FULL NAME**

Frank Marion Newman

(a) Residence, No. .... St. .... Ward. Canshaw, Mo  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**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 DELLA M. NEWMAN

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 11-26-1890

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
49 10 4

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. STOCK DEALER  
9. Industry or business in which work was done, as silk mill, 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) Sikeston, Mo

MOTHER 13. NAME Tom Newman

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

FATHER 15. MAIDEN NAME Joan Clark

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

17. INFORMANT (ADDRESS) Belle Newman

18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Park DATE 10-2, 1940

19. UNDERTAKER (ADDRESS) Ed. Wampler

20. FILED 9-30, 1940 J.M. Thompson Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-30, 1940

22. I HEREBY CERTIFY, That I attended deceased from 9/29, 1940, to 9/30, 1940

I last saw him alive on 9/30, 1940. Death is said to have occurred on the date stated above, at 2:50 a.m.

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

PERITONITIS Abc

Other contributory causes of importance:  
Perforation Bowel

Name of operation NONE Date of .....

What test confirmed diagnosis? ..... 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? .....

If so, specify .....  
(Signed) A. L. Smith M. D.  
(Address) Cape Girardeau  
Mo

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

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MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **31634**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **125**

Primary Registration District No. **3009**

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

1. PLACE OF DEATH:

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

(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 **Frank Marion Newman**

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 **49** Months **10** Days **4** If less than one day \_\_\_\_\_ 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 \_\_\_\_\_  
(City, town, or county) (State or foreign country)

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

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

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

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(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 **9** day **30**  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ 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.

Immediate cause of death **Peritonitis ac**

Duration

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

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

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

Major findings: Of operations **Perforations? Bowel**

Of autopsy **Known**

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 \_\_\_\_\_

SUPPLEMENTARY

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

MOTHER FATHER

