

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  
STANDARD CERTIFICATE OF DEATH

State File No. 32692

Registration District No. 609

Primary Registration District No. 4363

Registrar's No. 118

1. PLACE OF DEATH:

(a) County NEWTON  
 (b) City or town NEOSHO  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
SALE BOWMAN HOSPITAL  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 4 DAYS  
(Specify whether)  
 In this community 85 YEARS  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County NEWTON  
 (c) City or town Newtonia Mo.  
(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 SEPTEMBER Day 26  
 year 1940 hour 1 minute 30 P.M.  
 21. I hereby certify that I attended the deceased from Sept.  
21, 1940 to Sept. 26, 1940;  
 that I last saw her alive on Sept. 26, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Apoplexy, right side.

Due to Chronic interstitial  
nephritis, chronic endo-  
 Due to carditis with edema.

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

Major findings: \_\_\_\_\_  
 Of operations None  
 Of autopsy None

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?  
5112  
(Specify type of place)  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
 23. Signature Donald H. Salter, M.D. (M. D. or other) \_\_\_\_\_  
 Address Neosho, Mo. Date signed 9-30

8. (a) PRINT FULL NAME MINERVA CATHERINE TATUM

8. (b) If veteran, name war none 8. (c) Social Security No. none

4. Sex FEM. 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife J. B. Tatum 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased JANUARY 17 1855  
(Month) (Day) (Year)

8. AGE: Years 85 Months 8 Days 9 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Retired

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

MOTHER FATHER { 12. Name WILLIAM ADAMS

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

14. Maiden name SARA MARGARET WEEMS

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

16. (a) Informant's own signature Donald H. Salter

(b) Address Neosho, Mo.

17. (a) CREMATION (b) Date thereof 9-30-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: Neosho City Mo.

18. (a) Signature of funeral director Earl Thompson

(b) Address Neosho, Mo.

19. (a) 9-30-40 (b) Donald H. Salter, M.D.  
(Date received local registrar) (Registrar's signature)

RECEIVED

District Health Officer No. 6;

District File Number 1040-2719

Date Filed Oct 14 1940

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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 Gail K. Gay

Licensed Embalmer No. 4155

P. O. Address Neosho, 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.