

B. No. 2  
4-5-42  
5-17-  
I X 257

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

F 30874

State File No. \_\_\_\_\_  
Registrar's No. 3840

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

FILED SEP 21 1943

Registration District No. 149 Primary Registration District No. 1002

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
5331 Highland  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 1 year 3 Months  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5331 Highland  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ROBERT M NEWBY  
3. (b) If veteran, name war No 3. (c) Social Security No. None

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 6th day Sept  
year 1943 hour 2:50 minute A M.  
21. I hereby certify that I attended the deceased from Aug 26  
19 43 to Sept 5th, 19 43  
that I last saw him in alive on Sept 5, 19 43;  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced, Widower  
6. (b) Name of husband or wife Elizabeth Newby  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased June 15 1864  
(Month) (Day) (Year)

Immediate cause of death  
Coronary Thrombosis Duration 16 Hours

8. AGE: Years 79 Months 2 Days 21  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to Arterio Sclerosis several years  
Due to Chronic Nephritis unknown

9. Birthplace Illinois  
(City, town, or county) (State or foreign country)  
10. Usual occupation Retired--Farmer

Other conditions (Include pregnancy within 3 months of death) 1316

11. Industry or business \_\_\_\_\_  
12. Name James Newby  
13. Birthplace Illionos  
(City, town, or county) (State or foreign country)  
14. Maiden name Malissa Poenix  
15. Birthplace Illinois  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy NO  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs William Taylor  
(b) Address Quincy, Kansas  
17. (a) Burial (b) Date thereof 9/6/43  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation El Dorado Kansas  
18. (a) Signature of funeral director Zurk + Tobin  
(b) Address 20 West Linwood  
19. (a) 9-6-43 (b) T. E. Brown  
(Date received local registrar) (Registrar's signature)

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) (a) Means of injury \_\_\_\_\_  
23. Signature Dr John T. Shamer (M. D. or other) MD  
Address 1402 Bryant Bldg Date signed \_\_\_\_\_

(Licensed Embalmer's Statement on Reverse Side) R E Tho

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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, fact should be so stated above.**