

S. No. 2
M-9-4-41
5-17-39
PI X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

34513

State File No. _____

FILED NOV 17 1943

Registration District No. 157

Primary Registration District No. 3017

Registrar's No. 126

1. PLACE OF DEATH:

(a) County **Cooper**

(b) City or town **Boonville**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **----- / Home ---**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) **All of life.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Cooper**

(c) City or town **Boonville**
(If outside city or town limits, write "RURAL")

(d) Street No. **R.F.D. #1**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country **---**

3. (a) PRINT FULL NAME **Mrs. Schrildia Newell.**

3. (b) If veteran, name war **---**

3. (c) Social Security No. **---**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **28th** year **1943** hour **7** minute **20 p.** M.

4. Sex **Female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Daniel Newell**

6. (c) Age of husband or wife if alive **60** years

7. Birth date of deceased **March 14th 1884**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Sept 1** to **Sept 28** 19**43** and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Valvular Disease of Heart**

Duration **3**

8. AGE: Years Months Days If less than one day

59 6 14 hr. min.

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) **92d**

9. Birthplace **Cooper County, Missouri.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife.**

11. Industry or business **At Home.**

12. Name **John Bone.**

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

14. Maiden name **Lydia ???? ?**

15. Birthplace **???? 9-30-43?**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. F. A. Crawford,**

(b) Address **Boonville, Mo.**

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

(c) Place: burial or cremation **Pilot Grove, Mo.**

18. (a) Signature of funeral director **Goodman & Peller**

(b) Address **Boonville, Mo.**

19. (a) **Sept 28-43** (b) **Dr. Chas. Swap,**
(Date received local registrar) (Registrar's signature)

PHYSICIAN

Major findings: Of operations _____

Of autopsy _____

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 **A. J. Meredith** (M. D. or other) **Dr. Chas. Swap**
Address **Boonville, Mo.** Date signed **9/28/43**

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

27
1
2

RECEIVED

District Health Officer No. &

District File Number

Date Filed

11-3-43

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

J. H. Goodman

Licensed Embalmer No. 1178

P. O. Address

Boonville, 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, fact should be so stated above.