

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39381

State File No. _____

FILED DEC 7 1943
Registration District No. 200

Primary Registration District No. 0225

Registrar's No. 157

1. PLACE OF DEATH:

(a) County Vernon
(b) City or town Nevada, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
State Hosp #3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community 3 yrs + 5 mo
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Vernon
(c) City or town Nevada, MO
(If outside city or town limits, write "RURAL")
(d) Street No. State Hosp #3
(If rural, give location)
(e) Citizen of foreign country? U.S.C. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME EVA. NEWTON

3. (b) If veteran, name war no 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced SINGLE
6. (b) Name of husband or wife NO 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 28 1875
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
68 3 9 _____ hr. _____ min.

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

10. Usual occupation STENOGRAPHER

11. Industry or business _____

MOTHER FATHER { 12. Name UNKNOWN
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name UNKNOWN
15. Birthplace UNKNOWN (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Lillian Ringler
(b) Address 3003 E. Crawford St. Frank

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 1 1943
(Month) (Day) (Year)
(c) Place: burial or cremation St. Ann's, Kansas

18. (a) Signature of funeral director Allen J. Hays
(b) Address Nevada, Missouri

19. (a) 11-6-43 (b) Hazel B. Dewick
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV day 6
year 1943 hour 7 minute 15 a.m.
21. I hereby certify that I attended the deceased from May 14 1940
_____ 19____ to NOV. 6 1943
that I last saw her alive on NOV-6 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Degenerative Myocarditis
Due to UNKNOWN (possibly arteriosclerotic heart disease)
Due to _____

Other conditions INTERTRACHEAL TOXIC FRACTURE OF RIGHT FEMUR
(Include pregnancy within 3 months of death)
Major findings: Of operations NO
Of autopsy NONE

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) NO
(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 Frank M. Rogers (M. D. or other)
Address State Hosp #3 Date signed 11/6/43

Duration
UNKNOWN
PHYSICIAN
Underline the cause to which death should be charged statistically.

1331

RECEIVED

District Health Officer No. 7,

District File Number 11-43-1296

Date Filed 12-6-43

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. 4

working under my personal supervision.

Signed Mack A. Brunell

Licensed Embalmer No. 2529

P. O. Address Nevada mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1000
Registrar's No. 157

Registration District No. 360 Primary Registration District No. 6220

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

1. PLACE OF DEATH:

(a) County Vernon
 (b) City or town Rural: Washington Twp.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: State Hospital # 3
(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 Eva Newton
 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 S
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 28 1875
(Month) (Day) (Year)

8. AGE: Years 68 Months 3 Days 27
If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER {
 12. Name _____
 13. Birthplace _____
(City, town, or county) (State or foreign country)
 14. Maiden name _____
 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) Hazel B. Beecher
(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) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov 1943 year, _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____, 19____;
 that I last saw him/her alive on _____, 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Duration

Due to _____

Due to _____

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

Major findings: None
 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) fracture of right femur

(b) Date of occurrence Nov - 6 - 1943

(c) Where did injury occur? State Hospital # 3
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Nevada Missouri

While at work? No (Specify type of place) _____
 (e) Means of injury Fall

23. Signature Frank M. Roedel (M. D. or other) _____

Address State Hospital # 3 Date signed _____

SUPPLEMENTARY

S-39381