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FILED FEB 9 1944
Registration District No. **127**

Primary Registration District No. **5599**

Registrar's No. **10**

1. PLACE OF DEATH:

(a) County **Johnson.**
(b) City or town **Warrensburg, Rural**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Nagel Memorial Township
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **none**
(Specify whether years, months or days) **63 yrs 63.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Johnson**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **R. F. D. Warrensburg.**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Florence Adalade Newton.**

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

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced, **Widow**
6. (b) Name of husband or wife **Jasper Newton** 6. (c) Age of husband or wife if alive, **deceased** years
7. Birth date of deceased **Nov. 7, 1848.**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
95 **2** **9**
hr. min.

9. Birthplace **Lafayette Co., MO.**
(City, town, or county) (State or foreign country)

10. Usual occupation **House keeper.**

11. Industry or business

MOTHER FATHER { 12. Name **James Parker**
13. Birthplace **unknown Va.**
(City, town, or county) (State or foreign country)
14. Maiden name **Betty Ann Alkire**
15. Birthplace **unknown Va.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Minnie Ferguson**

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

17. (a) **Burial** (b) Date thereof **1-19-44.**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sunset Hill**

18. (a) Signature of funeral director **William J. Phillips**

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

19. (a) **Jan 18 1944** (b) **Leola M. Williams**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **16**
year **1944** hour **2** minute **10 P.M.**

21. I hereby certify that I attended the deceased from **July**
1941, to **Jan 16**, 19**44**

that I last saw her alive on **Jan 13**, 19**44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral thrombosis** Duration **1 week**

Due to **Arteriosclerosis** years

Due to **senility**

Other conditions (Include pregnancy within 3 months of death)

Major findings: 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) _____
(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) (c) Means of injury _____

23. Signature **William J. Phillips** (M. D. or other) _____
Address **Warrensburg, Mo.** Date signed **1-18-44**

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

APR 17 1901

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 P. A. Phillips
Licensed Embalmer No. 2320
P. O. Address Warrensburg 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.

FEB 1

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 164

Primary Registration District No. 5599

Registrar's No. 10

1. PLACE OF DEATH

(a) County Johnson
(b) City or town Warrensburg Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Hazel Hill 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

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 _____

3. (a) PRINT FULL NAME Florence A. 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 W

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Nov. 7 1904
(Month) (Day) (Year)

8. AGE: Years 95 Months 2 Days 1 If less than one day _____ min.

9. Birthplace Mo. (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 _____

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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 6
year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

Due to _____

Due to _____

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

Major findings: 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) _____

(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 _____

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

SUPPLEMENTARY

3319