

FILED APR 13 1944

Registration District No. 274

Primary Registration District No. 5931

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

1. PLACE OF DEATH:  
(a) County Pettis  
(b) City or town R.F.D.-1-Scobalia  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
R.F.D.-1 / Scobalia Mo.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community 7 months  
years, months or days

3. (a) PRINT FULL NAME James Henry Newbill  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. None

4. Sex M 5. Color or race Negro  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: 3 28 1864  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
79 11 18 hr. min.

9. Birthplace Camp Branch Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Train Porter

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name Peter Newbill  
13. Birthplace Ky (City, town, or county) (State or foreign country)  
14. Maiden name Frances Ann Henry  
15. Birthplace Ky (City, town, or county) (State or foreign country)

16. (a) Informant Della Newbill  
(b) Address R.F.D.-1-Scobalia, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 13-44  
(Month) (Day) (Year)  
(c) Place: burial or cremation Scobalia, Mo. Glenwood

18. (a) Signature of funeral director J. Ryce Alexander  
(b) Address 400 W. Cooper - Scobalia, Mo.

19. (a) 3-13-44 (Date received local registrar)  
(b) Mrs Anna Berger (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Pettis  
(c) City or town Scobalia, Mo.  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 9  
year 1944 hour 3 minute 0 M.  
21. I hereby certify that I attended the deceased from July 1 1944 to May 9 1944  
that I last saw him alive on July 8 1944  
and that death occurred on the date and hour stated above.  
Immediate cause of death Uremic Poisoning

Due to Enlarged Prostate and possibly kidney infection  
Due to \_\_\_\_\_  
Other conditions Senility  
(Include pregnancy within 3 months of death)

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?  
While at work: \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature M.B. Prichers (M. D. or other) (13)  
Address 151 1/2 W. Main, Scobalia Date signed 5/10/44

RECEIVED

District Health Officer No. 8

District File Number

Date Filed

4-12-14

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. Bryce Alexander

Licensed Embalmer No.

4245

P. O. Address

Sedalia, 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.

Registration District No. 294

Primary Registration District No. 5925

1. PLACE OF DEATH:

(a) County Pettis  
(b) City or town Rural Sedalia Twp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME

James H. Newbell

3. (b) If veteran name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced W

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

7. Birth date of deceased March 25  
(Month) (Day) (Year)

8. AGE: Years 79 Months 11 Days \_\_\_\_\_ (If less than one day, \_\_\_\_\_ min.)

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Mo.

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) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (Date received local registrar) (b) \_\_\_\_\_ (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 March Day \_\_\_\_\_ Year 1944 Hour \_\_\_\_\_ 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 Chronic Nephritis Duration \_\_\_\_\_

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) \_\_\_\_\_

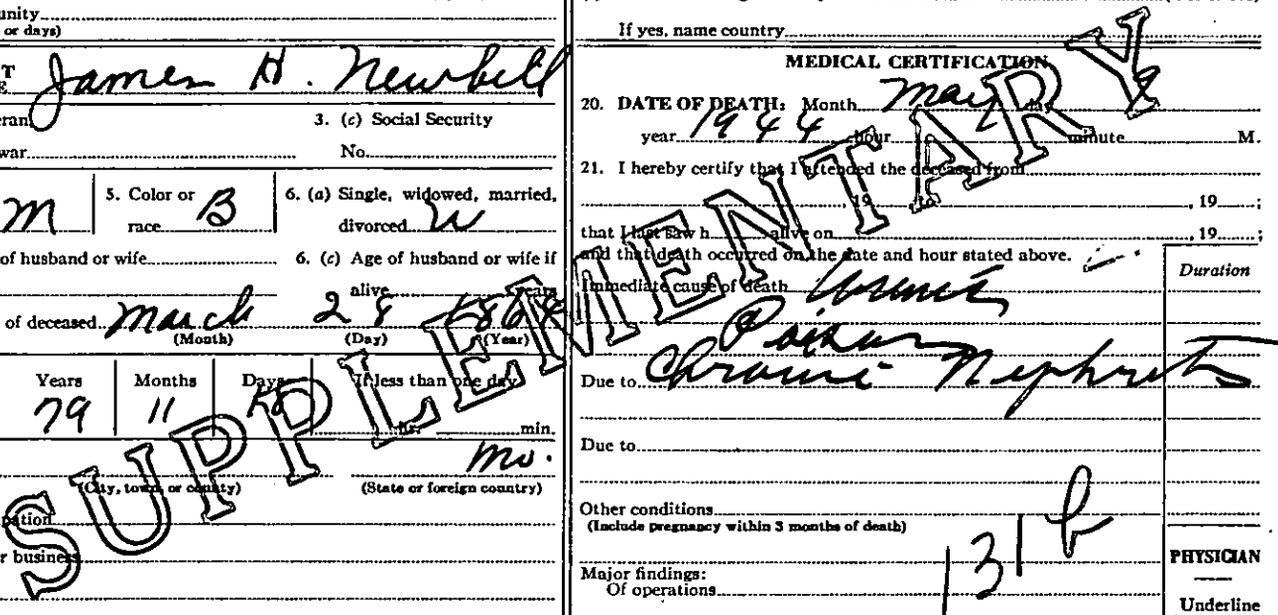
(b) Date of occurrence \_\_\_\_\_

(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) (c) Means of injury \_\_\_\_\_

23. Signature [Signature] (M.D. or other) \_\_\_\_\_  
Address [Address] Date signed \_\_\_\_\_



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

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