

FILED JUL 15 1944  
Registration District No. 15496

Primary Registration District No. 1002

Registrar's No.

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:  
4501 Indiana  
(If not in hospital or institution, write street number or location) 1  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community 25 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson <sup>48</sup>  
(c) City or town Kansas City <sup>3</sup>  
(If outside city or town limits, write "RURAL") <sup>6</sup>  
(d) Street No. 4501 Indiana  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 3  
year 1944 hour 12 minute 20 P.M.

21. I hereby certify that I attended the deceased from  
Jan 5th 1944 to July 3rd 1944  
that I last saw him alive on \_\_\_\_\_ 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion  
Duration \_\_\_\_\_

Due to ?  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) 94A

Major findings:  
Of operations none  
Of autopsy no  
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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature H. H. Dineen (M. D. or other) MD  
Address 1034 Maple Bldg Date signed 7-4-44

3. (a) PRINT FULL NAME

Raymond L Newton  
3. (b) If veteran, name war No  
3. (c) Social Security No. None

4. Sex M 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Maude E Newton 6. (c) Age of husband or wife if alive 71 years  
7. Birth date of deceased Dec 11 1870  
(Month) (Day) (Year)

8. AGE: Years 73 Months 6 Days 22  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Barber

11. Industry or business \_\_\_\_\_

12. Name J. F. Newton  
13. Birthplace Morganfield Ky.  
(City, town, or county) (State or foreign country)  
14. Maiden name Melinda Speakes  
15. Birthplace Kansas  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Maude E Newton

(b) Address 4501 Indiana

17. (a) Burial (b) Date thereof July 5 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director J. W. Wagner

(b) Address Kansas City Mo.

19. (a) 7-4-44 (b) E. Brown  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

**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.....

*A. R. Hauschild*

Licensed Embalmer No.....

*4159*

P. O. Address.....

*Kansas City*

**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.**