

RECEIVED SEP 28 1944  
DEPARTMENT OF HEALTH  
BUREAU OF THE CENSUS

# THE STATE BOARD OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

30546

State File No. \_\_\_\_\_

Registrar's No. 924

FILED SEP 23 1944  
Registration District No. \_\_\_\_\_

Primary Registration District No. 100

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

**1. PLACE OF DEATH:**

(a) County Buchanan

(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Missouri Methodist Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days (Specify whether)

In this community 50 years (years, months or days)

**3. (a) PRINT FULL NAME** Charles Eli Newton

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex male 0

5. Color or race white

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

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

7. Birth date of deceased: February 11 1853  
(Month) (Day) (Year)

8. AGE: Years 91 Months 7 Days 1 If less than one day hr. min.

9. Birthplace: Grundy County Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

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

12. Name Harrison Newton

13. Birthplace Grundy County Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Martha McCary

15. Birthplace Unknown Kentucky  
(City, town, or county) (State or foreign country)

16. (a) Informant Ora Hulse

(b) Address Rural #2, Wathena, Kansas

17. (a) Burial (b) Date thereof 9/14/1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Auburn, Cemetery

18. (a) Signature of funeral director Walter Meierhoffer

(b) Address 1302 Parson St., St. Joseph, Mo.

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")

(d) Street No. 921 Ridenbaugh  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month September day 12th.  
year 1944 hour 11 minute 00 A. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to Sept 11 1944

that I last saw him im alive on Sept 10 and that death occurred on the date and hour stated above.

Immediate cause of death: fracture of femur

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to fracture of femur

Other conditions fracture of femur  
(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:

(c) Accident, suicide, or homicide (specify) \_\_\_\_\_ 131

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

23. Signature Wm. Jacobson

Address 1317 Gratiot Blk. Date signed 9/14/44

1377

**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 Albert C. Harrington

Licensed Embalmer No. 3258 Missouri

P. O. Address St. Joseph, Missouri.

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St. Joseph  
(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 \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Charles Eli Newton

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

4. Sex M 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 \_\_\_\_\_ years

7. Birth date of deceased Feb 11 1944  
(Month) (Day) (Year)

8. AGE: Years 91 Months 7 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 \_\_\_\_\_

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) 9/14/44 (b) Walter J. Pickle  
(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 Sept 2  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, 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 fracture of L femur of L leg Duration 1 Mon

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) Accident 13

(b) Date of occurrence 9/7/44

(c) Where did injury occur? 916 Felix  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Home -- fell out of bed

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature W. M. Zottcherer M.D.

Address Welfare Bldg Date signed 9/2/44

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

SUPPLEMENTARY

1860  
18

30546