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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 23 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 12387

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1690

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: 1109 West 75 St. (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 45 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 48

(c) City or town Kansas City (If outside city or town limits, write "RURAL") 3

(d) Street No. 1109 West 75 St. (If rural, give location) 8

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Paul Newhouse

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Ma 0

5. Color or race Wh 1

6. (a) Single, widowed, married, divorced ~~married~~ 2

6. (b) Name of husband or wife Mrs Marie F Newhouse

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

7. Birth date of deceased Feb 24 1873 (Month) (Day) (Year)

8. AGE: Years 72 Months 1 Days 19 If less than one day hr. min.

9. Birthplace Belgium (City, town, or county) 4 (State or foreign country)

10. Usual occupation Landscape Gardener

11. Industry or business Retired

FATHER
12. Name No record
13. Birthplace Belgium (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name No record
15. Birthplace Belgium (City, town, or county) 4 (State or foreign country)

16. (a) Informant Frank J. Newhouse

(b) Address 3533 Flora

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-16-45 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Thos. E. Quirk

(b) Address 4316 Troost Ave.

19. (a) 4-14-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 13 year 45 hour 6 minute P M.

21. I hereby certify that I attended the deceased from 8-19 1944 to 4-13 1945 that I last saw him alive on 4-13 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis.

Due to Chronic Nephritis.

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations 131 b

Of autopsy

Duration

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 0

23. Signature Chas C. Montgomery (M. D. ~~or other~~)

Address Argyle Bldg Date signed 4-14-45

(Licensed Embalmer's Statement on Reverse Side) K.C. Mo

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 Thomas E. Turk

Licensed Embalmer No. 3775

P. O. Address K. C. 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.