

FILED OCT 19 1945

STANDARD CERTIFICATE OF DEATH

Registration District No. **174**

Primary Registration District No. **2035**

Registrar's No. **49**

1. PLACE OF DEATH:
(a) County Lafayette
(b) City or town Lexington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
River Front St 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 20 yrs years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Lafayette **54**
(c) City or town Lexington **3**
(If outside city or town limits, write "RURAL")
(d) Street No. River Front St **2**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) **1**
If yes, name country _____

3. (a) PRINT FULL NAME D.V. NEW
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 22 year 1945 hour 11 minute 30 P. M.
21. I hereby certify that I attended the deceased from Sept 10 1945 to Sept 22 1945 that I last saw him alive on Sept 19 1945 and that death occurred on the date and hour stated above.

4. Sex MA 5. Color or race W
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb 20 1890
(Month) (Day) (Year)

Immediate cause of death Cancer of adenocarcinoma
Duration _____

8. AGE: Years Months Days If less than one day
55 7 2 hr. _____ min.
9. Birthplace Howard Iowa
(City, town, or county) (State or foreign country)

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

10. Usual occupation laborer

Major findings: Of operations _____
Of autopsy 552

11. Industry or business _____
12. Name John F New
13. Birthplace Ill I
(City, town, or county) (State or foreign country)
14. Maiden name Alice Wilson
15. Birthplace Ill I
(City, town, or county) (State or foreign country)

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) _____ (e) Means of injury _____

16. (a) Informant Mrs Inez Wilson
(b) Address Lexington, MO
17. (a) Burial (b) Date thereof 9-25-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Lexington, MO
18. (c) Signature of funeral director Forest G. Temple
(b) Address Lexington, MO
19. (a) 12 Oct. 1945 (b) Thomas S. Galbraith
(Date received local registrar) (Registrar's signature)

23. Signature W. H. Hodson (M. D. or other)
Address Lexington, MO Date signed 9/24/45

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

MOTHER FATHER

1619

Fiedin

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed _____

10-18-45

JAN 23 1946

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 _____

Geo. McKean

Licensed Embalmer No. _____

2983

P. O. Address _____

Libington 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.