

S. No. 2
M-5-43
7-5-17-39
P 1 X36671

FILED MAY 8 1947

State File No. _____

Registration District No. 107

Primary Registration District No. 4176

Registrar's No. 18

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

1. PLACE OF DEATH:
 (a) County Bunkley
 (b) City or town Malden
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Home
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Bunkley
 (c) City or town Malden
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Betty Newport
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____
 4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced, Widowed
 6. (b) Name of husband or wife E. Newport
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased December 8 1858
(Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month April day 18
 year 1947 hour 4 minute 30 p. M.
 21. I hereby certify that I attended the deceased from October 1st 1947 to March 8th 1947
 that I last saw her alive on Apr. 6th 1947
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>88</u>	<u>4</u>	<u>10</u>	hr. _____ min.

Immediate cause of death Influenza
 Due to _____
 Due to _____

9. Birthplace Arkansas
(City, town, or county) (State or foreign country)
 10. Usual occupation Housework
 11. Industry or business _____
 12. Name William Luusaw
 13. Birthplace Arkansas
(City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace Unknown
(City, town, or county) (State or foreign country)

Other conditions Cerebral Haemorrhage
(Include pregnancy within 3 months of death)
 Major findings: Paralysis right side
 Of operations _____
 Of autopsy Autopsy

MOTHER FATHER
 16. (a) Informant Parolee Hubbard
 (b) Address Malden, Mo.
 17. (a) Burial (b) Date thereof 4-20-47
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Malden New Cemetery
 18. (a) Signature of funeral director Landess Funeral Home
 (b) Address Campbell, Missouri
 19. (a) 4/24/47 (b) J. S. Schuman
(Date received local registrar) (Registrar's signature)

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? _____ Means of injury _____
 23. Signature S. E. Mitchell M. D. or other M.D.
 Address Malden Mo. Date signed 4/20/47

Duration 3 weeks
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

RECEIVED

District Health Office No. 2,

District File Number 547-644

Date Filed 5-5-47

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..... *Christina M. Landess*

Licensed Embalmer No. 4227

P. O. Address..... *Campbell, 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.