

1-147  
5-17-39

National Office of Vital Statistics  
FILED MAR 19 1948

State File No. ....

Registration District No. 148

Primary Registration District No. 3024

Registrar's No. 15

1. PLACE OF DEATH:

(a) County HOWARD  
(b) City or town FAYETTE  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: NEK HOSPITAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 50 Days  
In this community years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri County Howard  
(c) City or town Fayette Mo  
(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 HOWARD NEWMAN  
3. (b) If veteran, name war .....

3. (c) Social Security No. None

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Mar day 9  
year 1948 hour 8 minute 30 A.M.

21. I hereby certify that I attended the deceased from 1-5-47 to 3-9-48  
that I last saw him alive on 3-9-48  
and that death occurred on the date and hour stated above. Duration 1 yr  
Immediate cause of death Metastatic Melanoma

4. Sex MALE 5. Color or race WHITE  
6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife Antoinette Sanders  
6. (c) Age of husband or wife if alive 60 years  
7. Birth date of deceased JUNE 27 1889  
(Month) (Day) (Year)

8. AGE: Years 58 Months 8 Days 11  
If less than one day hr. min.

9. Birthplace BROWN COUNTY OHIO  
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business FARM

12. Name FRANK NEWMAN

13. Birthplace OHIO  
(City, town, or county) (State or foreign country)

14. Maiden name MARTHA F DANIELS

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

16. (a) Informant Howard H Newman Jr  
(b) Address Stockton Mo

17. (a) Burial (b) Date thereof Mar 11 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Glasgow Mo  
(d) Signature of funeral director Cluddy  
(b) Address Glasgow Mo

19. (a) 3-13-1948 (b) Deborah Keen  
(Date received local registrar) (Registrar's signature)

Other conditions... (Include pregnancy within 3 months of death)

Major findings: Of operations...  
Of autopsy...  
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) .....

23. Signature W. B. ... (M. D. or other) M.D.  
Address Fayette Mo Date signed 3-10-48

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 3-18-48

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 \_\_\_\_\_

working under my personal supervision. \_\_\_\_\_ Registered Apprentice No. \_\_\_\_\_

Signed

*J. Walker Ainsley*

Licensed Embalmer No.

*3336*

P. O. Address

*Glasgow 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. April  
Registrar's No. 15

Registration District No. 140 Primary Registration District No. 3024

1. PLACE OF DEATH:  
(a) County Howard Fayette  
(b) City or town Howard Fayette  
(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 Howard Newman  
3. (b) If veteran, \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_  
+ name war \_\_\_\_\_

4. Sex m 5. Color or race w  
6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased: June 27 1888  
(Month) (Day) (Year)

8. AGE: Years 58 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min. \_\_\_\_\_  
Ohio

9. Birthplace: \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

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) \_\_\_\_\_ (b) \_\_\_\_\_  
(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 March Day \_\_\_\_\_ Year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 \_\_\_\_\_  
Due to Melanoma of 2 yrs  
Bach (Primary tumor)  
Due to \_\_\_\_\_

Other conditions: \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature Ira Bloom (M. D. or other) \_\_\_\_\_  
Fayette, Mo Date signed 3-29-48

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD  
MAY 31 1948  
FILED

SUPPLEMENTARY

MENTARY

S-8527-1948