

S. No. 300
DM-10-47
v. 5-17-39
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

12800

FILED APR 17 1948
Registration District No. 149

Primary Registration District No. 1002

State File No. _____

Registrar's No. 1410

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

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:
General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days
(Specify whether years, months or days) 53 years

3. (a) PRINT FULL NAME George W. Newman

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Grace D. Newman

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

7. Birth date of deceased 8 24 1867
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

80 7 5 hr. min.

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

10. Usual occupation Retired Printer

11. Industry or business _____

12. Name Robert Newman

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

14. Maiden name Sarah Allen

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

16. (a) Informant Mrs. Claire Campbell

(b) Address 2714 1/2 Guinotte

17. (a) Burial (b) Date thereof 4-1-1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Mrs. C.L. Forster

(b) Address Kansas City, Missouri

19. (a) 3-31-48 (b) Heraldine
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 2714 1/2 Guinotte
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 29
year 1948 hour 6 minute 30 A.M.

21. I hereby certify that I attended the deceased from March 25, 1948 to March 29, 1948
that I last saw him alive on March 29, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Benign prostatic hypertrophy with uremia

Due to _____

Due to _____

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

Major findings: 137a

Of operations _____

Of autopsy See above

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? _____

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

23. Signature [Signature] (M. D. or other) [Signature]
Address Med. Dir. Gen'l Hosp. Date 3-29-48

Handwritten signature

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 *Robert A. Herrmann*
Licensed Embalmer No. *3700*
P. O. Address *J. C. Me.*

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.