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MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Registration District No. **155**

Primary Registration District No. **4244**

Registrar's No. **64**

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

1. PLACE OF DEATH:

(a) County **Jasper**  
(b) City or town **Cartersville**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**203 West Main Street /**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community **50 years**  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jasper**  
(c) City or town **Cartersville**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **203 West Main**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Lyda May Newkirk**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **none**

4. Sex **F.** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **widowed**  
6. (b) Name of husband or wife **widowed** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **July 30 1868**  
(Month) (Day) (Year)

8. AGE: Years **79** Months **8** Days **23** If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace **UTICA N.Y.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **at home**

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name **Dr. W.A. Dumbauld**  
13. Birthplace **unknown OHIO**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Jennie Walker**  
15. Birthplace **unknown OHIO**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Son Richard Newkirk**  
(b) Address **Joplin, Mo.**

17. (a) **burial** (b) Date thereof **4/22/48**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Mt. Hope Cemetery**

18. (a) Signature of funeral director **Hedge-Lewis**  
(b) Address **Webb City, Mo.**

19. (a) **APR. 23, 1948** (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **23**  
year **1948** hour **8:30** minute **A.** M.

21. I hereby certify that I attended the deceased from **November 16 to April 29, 1948**  
that I last saw her alive on **April 14, 1948**  
and that death occurred on the date and hour stated above.

Immediate cause of death **General Carcinomatosis** Duration **1 yr.?**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Major findings:  
Of operations **X**  
Of autopsy **X**

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 **O. T. Blum** (M. D. or other) **M.D.**  
Address **607 Main Joplin, Mo.** Date signed **4-23-48**

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN  
Underline the cause to which death should be charged statistically.

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**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.....

*Leonard J. Lewis Jr.*, Registered Apprentice No. *46*  
working under my personal supervision.

Signed *Richard Gray Lewis*

Licensed Embalmer No. *4405*

P. O. Address *Webb City, 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. may 64  
Registrar's No. 64

Registration District No. 155

Primary Registration District No. 4244

1. PLACE OF DEATH:

(a) County Jasper  
(b) City or town Carterville  
(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 (Specify whether years, months or days).

3. (a) PRINT FULL NAME Lydell M. Newkirk

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive.

7. Birth date of deceased July 30 1948  
(Month) (Day) (Year)

8. AGE: Years 79 Months Days 0 If less than one day hr. min.

9. Birthplace n.y.  
(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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation.

18. (a) Signature of funeral director.

(b) Address.

19. (a) (Date received local registrar) (b) (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 May year 1948 hour 23 minute 3 M.

21. I hereby certify that I attended the deceased from May 23 1948 to May 23 1948; that I last saw him alive on May 23 1948 and that death occurred on the date and hour stated above. Immediate cause of death.

Due to Ca. of stomach (from symptoms)  
Due to ?

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations none  
Of autopsy none 46B

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) Manner of injury

23. Signature D. T. Delaney (M. D. or other) MD  
Address 607 7th St. Jasper Mo. Date signed 5-11-48

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

SUPPLEMENTARY

5-13138