

No. 300
-10-47
-5-17-39
-I 3906

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

33556

State File No. _____

FILED NOV 5 1948

Registration District No. 277

Primary Registration District No. 3045

Registrar's No. 95

1. PLACE OF DEATH:

(a) County Mississippi

(b) City or town Charleston
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
711 State St.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 67 years
years, months or days

3. (a) PRINT FULL NAME Samuel Milton Newcum

3. (b) If veteran, name was Not Known

3. (c) Social Security No. None Known

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Laura Newcum, Dec'd 1942

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

7. Birth date of deceased: December 11 1856
(Month) (Day) (Year)

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

91	10	4	hr. min.
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9. Birthplace Fredericktown, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business None

MOTHER FATHER { 12. Name Bennett Newcum

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

14. Maiden name Sarah Frances Harris

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

16. (a) Informant Miss Leta Newcum

(b) Address Charleston, Missouri

17. (a) Burial (b) Date thereof 10-18-1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem., Charleston

18. (a) Signature of funeral director Joe P. Nunnallee
(b) Address Charleston, Mo.

19. (a) 10-30-48 (b) Mrs. John Bondurant
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi

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

(d) Street No. 711 State St.
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 15th
year 1948 hour 10:00 minute 45 A.M.

21. I hereby certify that I attended the deceased from Sept 11, 1948, to Oct 15, 1948, that I last saw him alive on Oct 15, 1948, and that death occurred on the date and hour stated above.

Immediate cause of death Ventricular Fibrill. Duration 170+

Due to Myocarditis

Due to Senility

Other conditions Prostatitis 2nd
(Include pregnancy within 3 months of death)

Major findings:
Of operations none of 36

Of autopsy none of 36

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? U

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

23. Signature E. Chee Polwing (M. D. or other)
Address Charleston, Mo. Date signed 10/23/48

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

RECEIVED

RECEIVED

District Health Office No. 2,

District File Number 1148-1481

Date Filed 11-3-48

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Joe R. Nunnallee

Licensed Embalmer No. 4413

P. O. Address Charleston, W.V.

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.