

FILED NOV 18 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37176

4545

BIRTH NO. _____		REG. DIST. NO. <u>147</u>		PRIMARY REG. DIST. NO. <u>1802</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>Kansas City</u>		c. LENGTH OF STAY (If in this place) <u>11 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>		d. STREET ADDRESS (If rural, give location) <u>3015 Indiana</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Research Hospital</u>							
3. NAME OF DECEASED (Type or Print) a. (First) <u>Lois</u>		b. (Middle) <u>Wright</u>		c. (Last) <u>Newell</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 29 1950</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Feb. 13 1869</u>		9. AGE (In years last birthday) <u>81</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>T. T. Wright</u>		13b. MOTHER'S MAIDEN NAME <u>Hulda Meachum</u>		14. NAME OF HUSBAND OR WIFE <u>Samuel J. Newell, Jr.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Lista Lois Shawgo (Neice)</u>		ADDRESS <u>K. C. Mo.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>diabetic coma</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>followed Reduphion</u> DIE TO (c) <u>of fractured hip</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>29 1/2 hrs</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>123</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, factory, street, office bldg., etc.) <u>Hospital</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Kansas City Jackson, Mo.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>10-24-50</u>		21e. (INJURY OCCURRED WHILE AT WORK) <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>fell from bed</u>			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>7:50 Am.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>D.R. Black MD</u>				23b. ADDRESS <u>[Address]</u>		23c. DATE SIGNED	
24a. BURIAL OR CREMATION REMOVAL (Specify)		24b. DATE <u>Oct. 29, 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Holton Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Holton, Kansas</u>	
DATE REC'D BY LOCAL REG. <u>10-29-50</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. C. L. Forster</u>		ADDRESS <u>Kansas City Mo.</u>	

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

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.

Signed.....
Student Embalmer

Student Embalmer No.....

Signed *J. W. Herrick*

Licensed Embalmer No. *3599*

P. O. Address *H. C. 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.