

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33248

FILED OCT 22 1951

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 861-A

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. b. COUNTY WRIGHT	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPRINGFIELD	c. LENGTH OF STAY (In this place) 1 DAY	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN MTN. GROVE 1141	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOHN'S HOSPITAL		d. STREET ADDRESS (If rural, give location) MAIN ST.	

3. NAME OF DECEASED (Type or Print) CHESTER GARFIELD NEWTON	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) OCT. 8 1951
--	------------	-------------	-----------	--

5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 12-2-1884	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Mins.
--------------------	-------------------------------	---	-----------------------------------	---	------------------------	----------------------	-----------------------	-----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOTEL MANDAGER	10b. KIND OF BUSINESS OR INDUSTRY HOTEL MDG.	11. BIRTHPLACE (State or foreign country) ODEN MO.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	---	---	--

13a. FATHER'S NAME WILLIAM NEWTON	13b. MOTHER'S MAIDEN NAME Linnie Hickson	14. NAME OF HUSBAND OR WIFE LOLA POOL
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs. Lola Newton	ADDRESS 7th. Grove Mo.
--	-------------------------------------	---	-------------------------------

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Hours Several years.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary embolism		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic heart disease with auricular fibrillation DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I attended the deceased from **6-27 1951**, to **10-8 1951**, that I last saw the deceased alive on **10-8 1951**, and that death occurred at **4:00 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE Homer C. Marshall, M.D., Professional Elder	23b. ADDRESS	23c. DATE SIGNED 10-11-51
---	--------------	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE OCT. 11/51	24c. NAME OF CEMETERY OR CREMATORY STEEL MEMORIAL	24d. LOCATION (City, town, or county) (State) HARTVILLE MO.
---	-----------------------------	--	--

DATE REC'D BY LOCAL REG. 10-16-51	REGISTRAR'S SIGNATURE W.S. Handley	25. FUNERAL DIRECTOR'S SIGNATURE Rev Barber	ADDRESS 7th. Grove
--	---	--	---------------------------

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

0346

SEP 12 1952

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

R. W. Barber

Licensed Embalmer No. 3848

P. O. Address Mt. Grove, Pa.

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.