

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43847

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 359 PRIMARY REG. DIST. NO. 6219 Registrar's No. 27

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

1. PLACE OF DEATH a. COUNTY <u>VERNON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>VERNON</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL DRYWOOD</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL DRYWOOD</u>	
c. LENGTH OF STAY (in this place) <u>15 MONTHS</u>		d. STREET ADDRESS (If rural, give location) <u>4 MILES WEST SHELDON MO</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>ROSE</u>	b. (Middle) <u>MARY</u>	c. (Last) <u>NEWTON</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>DEC. 9 1951</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>INFANT (1)</u>	8. DATE OF BIRTH <u>SEPT 5, 1950</u>	9. AGE (In years last birthday) <u>1</u> IF UNDER 1 YEAR Months Days <u>3 3</u> IF UNDER 12 HRS. Hours Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (State or foreign country) <u>MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>DALE NEWTON</u>	13b. MOTHER'S MAIDEN NAME <u>ELSIE STARBUCK</u>	14. NAME OF HUSBAND OR WIFE <u>✓</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Dale Newton</u> ADDRESS <u>Sheldon, Mo.</u>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>12 Day</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Intestinal Infection Virus and cerebral deterioration</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR
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22. I hereby certify that I attended the deceased from Dec 6, 1951, to Dec 8, 1951, that I last saw the deceased alive on Dec 8, 1951, and that death occurred at 5 A. m., from the causes and on the date stated above.

23a. SIGNATURE (Name or title) <u>H. B. Bernard</u>	23b. ADDRESS <u>Sheldon Mo.</u>	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>Dec 12, 1951</u>	24c. NAME OF CEMETERY OR CREMATORY <u>SHELDON</u>	24d. LOCATION (City, town, or county) (State) <u>SHELDON MO</u>
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DATE REC'D BY LOCAL REG. <u>Dec 24 1951</u>	REGISTRAR'S SIGNATURE <u>Mrs Ruth Faith</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>H. B. Bernard</u> ADDRESS <u>Becky Sheldon Mo</u>
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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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed *S. Bernard Beeny*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. *4161*

P. O. Address *Sheldon 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.