

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 7472

FILED FEB 26 1954

REG. DIST. NO. 337 PRIMARY REG. DIST. NO. 3074 Registrar's No. 20

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Scott</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission).<br>a. STATE <b>Missouri</b> b. COUNTY <b>Stoddard</b>   |   |
| b. CITY (If outside corporate limits, write RURAL and give township)<br><b>Sikeston</b>  |  | c. LENGTH OF STAY (in this place)<br><b>16 Days</b>  | c. CITY OR TOWN <b>Dexter</b>   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Mo. Delta Community Hospital</b>   |  | d. Is Residence within limits of a city or incorporated town?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>a. (First) <b>Carrie</b> b. (Middle) <b>----</b> c. (Last) <b>Newhouse</b>  |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>2 12 1954</b>  |   |
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>White</b>  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>   | 8. DATE OF BIRTH<br><b>10-5-1872</b>  |
| 9. AGE (In years last birthday) <b>81</b>  |  | IF UNDER 1 YEAR<br>Months <b>4</b>   | IF UNDER 24 HRS.<br>Hours <b>7</b> Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>  | 11. BIRTHPLACE (City and State or Foreign Country)<br><b>Yellow Springs, Ohio</b>   |
| 13a. FATHER'S NAME<br><b>Dr. Edwin Thorne (Dec.)</b>   |  | 13b. MOTHER'S MAIDEN NAME<br><b>Rebecca Stewart (Dec.)</b>   | 14. NAME OF HUSBAND OR WIFE<br><b>S. E. Newhouse</b>                                |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>---</b>  | 17. INFORMANT'S SIGNATURE OR NAME<br><b>S.E. Newhouse, Dexter, Mo.</b>              |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Thrombosis</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving DUE TO (b) rise to the above cause (a) stating the underlying cause last.<br><br>DUE TO (c)<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>Acute Hepatitis 332X</b> |   |
| 19a. DATE OF OPERATION<br><b>2-9-54</b>  | 19b. MAJOR FINDINGS OF OPERATION<br><b>Enlarged Liver - Ascites</b>                                    |  | 20. AUTOPSY?<br>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) m.   | 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 <b>1-25</b> , 19 <b>54</b> , to <b>2-12</b> , 19 <b>54</b> , that I last saw the deceased alive on <b>2-12</b> , 19 <b>54</b> , and that death occurred at <b>12:20 P. m.</b> , from the causes and on the date stated above. |  |  |   |
| 23a. SIGNATURE<br><b>Dr. M. Daxo M.D.</b>  |  | 23b. ADDRESS<br><b>Mo. Newhouse Mo.</b>  | 23c. DATE SIGNED<br><b>2-13-54</b>  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 24b. DATE<br><b>2-15-54</b>  | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Dexter</b>  | 24d. LOCATION (City, town, or county) (State)<br><b>Dexter, Missouri</b>            |
| DATE REC'D BY LOCAL REG.<br><b>2-18-54</b>   | REGISTRAR'S SIGNATURE<br><b>Mrs. Alta Hunter</b>   | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><b>Strickland-Rainey Dexter, Mo.</b>   |   |

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

RECEIVED FEB 23 1954

SCOTT COUNTY HEALTH CENTER

OO, FILE NO. 254.43

MAR 30 1954

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emba

by me, or by ....., Student Embalmer No.,

working under my personal supervision.:

Student .....  
Signature of Student Embalmer

Signed *J. J. Smith* .....  
Licensed Embalmer No. 347

P. O. Address *W. Dept.* .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fa  
to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.