

FILED FEB 24 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4992

State File No.

494

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 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 name of township) <u>Kansas City</u>		c. CITY OR TOWN <u>Kansas City</u>	
c. LENGTH OF STAY (in this place) <u>35 yrs.</u>		Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Bases Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>2944 Forest Street</u>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) <u>Mary</u>	b. (Middle) <u>ESTHER</u>	c. (Last) <u>NEWMAN</u>	(Month) <u>Feb.</u>	(Day) <u>2-</u>	(Year) <u>1955</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>May 5-1877</u>	9. AGE (in years last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u>-</u>	IF UNDER 24 HRS. Days <u>-</u>	Hours <u>-</u>	Min. <u>-</u>
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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 <u>At Home</u>	11. BIRTH PLACE (City and State or Foreign Country) <u>Leim Co, Iowa</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>John Oliphant</u>	13b. MOTHER'S MAIDEN NAME <u>Permelia Hoff</u>	14. NAME OF HUSBAND OR WIFE <u>Perry Newman</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. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Mr. H. W. Smith</u>	ADDRESS <u>Della, Iowa</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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerosis</u>		<u>7 yrs</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u>		<u>7 yrs</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<u>4500</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) m.	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 5-10-54, 1954, to 2-2-55, 1955, that I last saw the deceased alive on 2-2-55, 1955, and that death occurred at 1:20 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Frank Paul Laurence</u>	23b. ADDRESS <u>428 South Whiteave</u>	23c. DATE SIGNED <u>2-2-55</u>
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24a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Feb. 3-1955</u>	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) <u>Cedar Rapids, Iowa</u>
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DATE REC'D BY LOCAL REG. <u>2-3-55</u>	REGISTRAR'S SIGNATURE <u>meva mussall</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>C. H. Blackman</u>	ADDRESS <u>San Francisco, Mo.</u>
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WRITE PLAINLY—USING UNFAADING 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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *W.C. Rinne*.....

Licensed Embalmer No. *487*.....

P. O. Address *90 m.*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.