

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12081**
1807

FILED MAY 16 1955

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) 33 days		8. STREET ADDRESS (If rural, give location) 3108 E. 10th	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION General Hospital # 1			

3. NAME OF DECEASED (Type or Print) a. (First) Marvin	b. (Middle) A.	c. (Last) Newman	4. DATE OF DEATH (Month) (Day) (Year) 4 23 55
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 8-20-00
9. AGE (In years last birthday) 54		IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance man		10b. KIND OF BUSINESS OR INDUSTRY Oil Field Equip.	11. BIRTHPLACE (City and State or Foreign Country) Blue Eye, Mo.
12. CITIZEN OF WHAT COUNTRY? USA			

13a. FATHER'S NAME Alec N. Newman	13b. MOTHER'S MAIDEN NAME No Record	14. NAME OF HUSBAND OR WIFE Dorothy O. Newman
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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) No	16. SOCIAL SECURITY NO. 500-09-8792	17. INFORMANT'S SIGNATURE OR NAME Mrs. Dorothy O. Newman	ADDRESS 3108 E. 10th
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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, asthma, 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) Lobar pneumonia		
	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 checked="" 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 2/18/1955, to 4/23/1955, that I last saw the deceased alive on 4/23/1955, and that death occurred at 12:40am., from the causes and on the date stated above.

23a. SIGNATURE B.I. Burns (Degree or title)	23b. ADDRESS K.C., Mo.	23c. DATE SIGNED 4/23/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-26-55	24c. NAME OF CEMETERY OR CREMATORY Hazelwood	24d. LOCATION (City, town, or county) (State) Springfield, Mo.
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DATE REC'D BY LOCAL REG. 4-23-55	REGISTRAR'S SIGNATURE Neva Marshall	25. FUNERAL DIRECTOR'S SIGNATURE Wagner Funeral Home	ADDRESS K 6 Mo
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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 Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *Alvin B. Naunschuld*

Licensed Embalmer No..... *419*

P. O. Address..... *Kansas City*

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.