

FILED APR 18 1957

STANDARD CERTIFICATE OF DEATH

14399
STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 4461 Registrar's No. 124

1. PLACE OF DEATH a. COUNTY St. Francois				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Francois			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bismarck			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Bismarck		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Length of stay in lb		d. STREET ADDRESS 0940 0 (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Caswell Walker Newcomb <i>First Middle Last</i>				4. DATE OF DEATH April 10 1957 <i>Month Day Year</i>			
5. SEX male <input type="radio"/>	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 1 1870		9. AGE (In years last birthday) 86 IF UNDER 1 YEAR: Months 4 Days 9 Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Caledonia Mo.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James R. Newcomb				14. MOTHER'S MAIDEN NAME Elizabeth McCoy			
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. 520-12-1213		17. INFORMANT Mrs. Zoe Harbison, Bismarck Mo. <i>Address</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumo. pneumonia DUE TO (b) Ch. interstitial nephritis DUE TO (c) 592X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) Arteriosclerotic psychosis & Head disease							INTERVAL BETWEEN ONSET AND DEATH 6 Days
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>				
20c. TIME OF INJURY Hour Month Day Year a. m. p. m. 			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from April 1-57 to April 10, 1957 and last saw her alive on 4-8-57 Death occurred at 6:45 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE H. D. Kaebel M.D. (Degree or title)				22b. ADDRESS Bismarck Mo		22c. DATE SIGNED 4-12-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 4-13-57	23c. NAME OF CEMETERY OR CREMATORY Masonic Cemetery		23d. LOCATION (City, town, or county) (State) Bismarck, Missouri		
24. FUNERAL DIRECTOR White Funeral Home, Bismarck, Mo. <i>and J. White</i>				25. DATE RECD. BY LOCAL REG. April 12, 1957		26. REGISTRAR'S SIGNATURE Ether Rudloff	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

APR 18 1957

10-11-001

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 *Russell J. White*

Licensed Embalmer No. *3012*

P. O. Address *Imitor*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.