

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-018403

STATE FILE NUMBER

FILED MAY 23 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2312

300
1-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE Kansas b. COUNTY Wyandotte	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City 8-1508	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 47th & Central few hrs.		d. STREET ADDRESS (If outside, give location) 1034 Co. Line Rd.	
3. NAME OF DECEASED (Type or print) First RALPH Middle EATON Last NEWELL		4. DATE OF DEATH Month May Day 5 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 25, 1908
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY J. C. Nichols Co.	11. BIRTHPLACE (City and state or country) Newton, Iowa
13a. FATHER'S NAME Clayton E. Newell		13b. MOTHER'S MAIDEN NAME Ina Eaton	14. NAME OF HUSBAND OR WIFE Emma Bell Newton
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 480-10-9215	17. INFORMANT Address Newton, Iowa Emma Bell Newell, 511 E 2nd St.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Death by Suffocation			INTERVAL BETWEEN ONSET AND DEATH 9:25³⁰ 6
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (Not related to the terminal disease condition given in PART I.) Fractured Rt. Femur & Left Ankle			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Building underground garage	
20c. TIME OF INJURY 10:30 a.m. 5-5-58		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) cust job Kansas City Jackson MO.	
20e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION Newton, Iowa	
21. I attended the deceased from _____ to _____ and last saw him/her alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Hugh H. Owens		22b. ADDRESS 1034 Realty Bldg	
22c. DATE SIGNED 5-6-58			
23a. BURIAL, REMOTION, REMOVAL (Specify) Removal		23b. DATE 5-7-58	
23c. NAME OF CEMETERY OR CREMATORY Newton Memorial Cem.		23d. LOCATION (City, town, or county) (State) Newton, Iowa	
24. FUNERAL DIRECTOR Melody-McGilley-Eylar		25. DATE RECD. BY LOCAL REG. 5-6-58	
ADDRESS 1800 E. Linwood Kansas City, Mo		26. REGISTRAR'S SIGNATURE neva munnell	

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

22

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 *James W. Wair*

Licensed Embalmer No. *4650*

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