

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-022959

STATE FILE NUMBER

FILED JUL 9 1958

Registration District No. 301 Primary Registration District No. 4458 Registrar's No. 598

S. 300  
1-57  
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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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Ripley</i>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Missouri</i> b. COUNTY <i>Ripley</i>                   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <i>Doniphan</i>  |                                  | c. CITY OR TOWN <i>Doniphan</i>   |   |
| c. FULL NAME OF HOSPITAL OR INSTITUTION <i>Community Hospital</i>   |                                  | d. STREET ADDRESS (If outside, give location) <i>0910 409 Locust Street</i>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <i>William</i> Middle <i>Rowland</i> Last <i>Newlin</i>  |                                  | 4. DATE OF DEATH<br>Month <i>June</i> Day <i>27</i> Year <i>1958</i>  |   |
| 5. SEX<br><i>Male</i>   | 6. COLOR OR RACE<br><i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>August 21, 1891</i>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Machinist</i>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Factory</i>   | 11. BIRTHPLACE (City and state or country)<br><i>Bevier, Missouri</i>                             |
| 13a. FATHER'S NAME<br><i>Lincoln Newlin</i>   |                                  | 13b. MOTHER'S MAIDEN NAME<br><i>Rachel Moore</i>  | 14. NAME OF HUSBAND OR WIFE<br><i>Lela Mae Newlin</i>   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><i>No</i>  |                                  | 16. SOCIAL SECURITY NO.<br><i>31-07-7334</i>  | 17. INFORMANT<br>Address <i>Lela Newlin Doniphan Mo</i>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i><br>DUE TO (b) <i>Generalized arteriosclerosis</i><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><i>7 days</i><br><i>5 years</i>                               |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)   |                                  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT <input 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.)  |   |
| 20c. TIME OF INJURY<br>Hour _____ a.m. _____ p.m.   |                                  | 20d. INJURY OCCURRED WHILE AT <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 <i>6/18/58</i> to <i>6/27/58</i> and last saw <sup>her</sup> <sub>him</sub> alive on <i>6/27/58</i> .<br>Death occurred at <i>4:15 P</i> m on the date stated above; and to the best of my knowledge, from the causes stated.  |                                  |   |   |
| 22a. SIGNATURE (Degree or title)<br><i>Frank C. Johnson, M.D.</i>   |                                  | 22b. ADDRESS<br><i>Doniphan, Mo.</i>  |   |
| 22c. DATE SIGNED<br><i>6/30/58</i>  |                                  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  | 23b. DATE<br><i>6-29-58</i>      | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Doniphan Cemetery</i>  | 23d. LOCATION (City, town, or county) (State)<br><i>Doniphan Missouri</i>                         |
| 24. FUNERAL DIRECTOR<br><i>Ray Measor, Doniphan, Mo.</i>  |                                  | 25. DATE RECD. BY LOCAL REG.<br><i>7-5-58</i>   | 26. REGISTRAR'S SIGNATURE<br><i>Ruth Johnston Deputy</i>  |

JUL 23 1958

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 *Ray Measat* .....

Licensed Embalmer No. *3743* .....

P. O. Address *Doniphan,* .....

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.