

**FRI DIVISION OF HEALTH - STANDARDS CERTIFICATE OF DEATH**

**FILED VS OCT 23 1959**

**59-036314**

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4878 STATE FILE NUMBER

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, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in lb <u>40 yrs</u>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>7611 Baltimore</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Morton</u> Middle <u>I.</u> Last <u>Newell</u>				4. DATE OF DEATH Month <u>10</u> - Day <u>10</u> - Year <u>1959</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>7/25/97</u>	9. AGE (last birthday) <u>62</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	IF UNDER 1 YEAR Hours	IF UNDER 24 HR Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pres. of Best Stamp Co.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Best Stamp Co.</u>		11. BIRTHPLACE (City and state or country) <u>Holton, Kansas</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Samuel H. Newell</u>			13b. MOTHER'S MAIDEN NAME <u>Ina Shumate</u>			14. NAME OF HUSBAND OR WIFE <u>Frances Newell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes W.W.I Army</u>			16. SOCIAL SECURITY NO. <u>499-09-8921</u>		17. INFORMANT Address <u>Mrs. Frances Newell 7611 Baltimore K.C. Mo.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>malignant neoplasm - prob. squamous cell carcinoma. Site of origin - mouth?</u>								INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)					
20c. TIME OF INJURY Hour p.m.	Month, Day, Year								
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 <u>4/27/59</u> to <u>10/10/59</u> and last saw her/him alive on <u>10/9/59</u> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.									
22. SIGNATURE (Degree or title) <u>James R. McVay M.D.</u>				22b. ADDRESS <u>814 U.F.W. Bldg.</u>				22c. DATE SIGNED <u>10/10/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10/12/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>		23d. LOCATION (City, town, or county) <u>Kansas City, Mo.</u>		(State)		
24. FUNERAL DIRECTOR <u>Mellody-McGilley-Eylar 20 W. Linwood K.C.</u>				25. DATE RECD. BY LOCAL REG. <u>10-10-59</u>		26. REGISTRAR'S SIGNATURE <u>Melva Marshall</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

James R. McVay

Geo. R. McVay  
V. F. W. Bldg.  
VA-5600

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Wm. H. Lentz

Licensed Embalmer No. 5038

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.