

VITAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039745

FILED VS. NOV 23 1959 132

3021

195

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Grundy</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Grundy</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Trenton,</u>		Length of stay in 1b <u>3 yrs</u>	c. CITY OR TOWN <u>Trenton</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>Neal's Nursing Home</u> <u>1411 Main St.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1713 Lulu</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARTHA JANE NEWMAN</u>			4. DATE OF DEATH Month Day Year <u>NOV 19, 1959</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/3/78</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Harrison Co., Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Oliver Elsworth Newman</u>		13b. MOTHER'S MAIDEN NAME <u>Angetta Hudson</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Mrs August Kroeger, Trenton, 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>Myocarditis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio-sclerosis and Arterial Hypertension</u> DUE TO (c) <u>Also Had Suffered Hemiplegia -</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u> <u>9 wks</u>	
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 a.m. 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>8-10-1958</u> to <u>11-19-59</u> and last saw her/him alive on <u>11-13-1959</u> Death occurred at <u>12:30 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>Mrs J. Mason MD</u>			22b. ADDRESS <u>Trenton Mo</u>		22c. DATE SIGNED <u>11/20/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>11/21/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Edinburg, Cemetery</u>		23d. LOCATION (City, town, or county) <u>Grundy Co., Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Gipson Funr.Hm., Trenton, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>11-21-59</u>	26. REGISTRAR'S SIGNATURE <u>Gene Fair</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

~~_____~~, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Hal Stoumburg

Licensed Embalmer No. 3408

P. O. Address to Trenton,

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.