

**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS DEC 21 1959**

'59 0 4 4 2 7 7

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5850

|   |  |   |  |
|---|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Jackson</b>  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> COUNTY <b>Saline</b> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>                |  | Length of stay in 1b <b>10 days</b>   |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>General Hospital</b> |  | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |  |
|   |  | d. STREET ADDRESS <b>General Delevrey</b> (If outside, give location)   |  |
|   |  | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  |

|   |  |  |                         |  |                               |  |
|---|--|--|-------------------------|--|-------------------------------|--|
| <b>3. NAME OF DECEASED</b> (Type or print)                      |  |  | <b>4. DATE OF DEATH</b> |  |                               |  |
| First <b>VERINDA</b> Middle <b>Elizabeth</b> Last <b>NEWELL</b> |  |  | Month <b>12</b>         |  | Day <b>3</b> Year <b>1959</b> |  |

|                                |  |   |  |   |  |  |  |  |  |                        |  |                       |  |
|--------------------------------|--|---|--|---|--|--|--|--|--|------------------------|--|-----------------------|--|
| <b>5. SEX</b><br><b>Female</b> |  | <b>6. COLOR OR RACE</b><br><b>White</b> |  | <b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/><br><b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/> |  | <b>8. DATE OF BIRTH</b><br><b>12-26-68</b> |  | <b>9. AGE (last birthday)</b><br><b>90</b> |  | <b>IF UNDER 1 YEAR</b> |  | <b>IF UNDER 24 HR</b> |  |
|                                |  |   |  |   |  |  |  |  |  | Months                 |  | Days                  |  |
|                                |  |   |  |   |  |  |  |  |  | Hours                  |  | Min.                  |  |

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during life, even if retired)<br><b>Homemaker</b> |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>Home</b> |  | <b>11. BIRTHPLACE</b> (City and state or country)<br><b>Kirksville, Missouri</b> |  | <b>12. CITIZEN OF WHAT COUNTRY</b><br><b>U.S.A.</b> |  |
|--|--|---|--|--|--|---|--|

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| <b>13a. FATHER'S NAME</b><br><b>Amos Coghill</b> |  | <b>13b. MOTHER'S MAIDEN NAME</b><br><b>Lena "unknown"</b> |  | <b>14. NAME OF HUSBAND OR WIFE</b><br><b>Charles W. Newell</b> |  |
|--|--|---|--|--|--|

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> |  | <b>16. SOCIAL SECURITY NO.</b><br><b>None</b> |  | <b>17. INFORMANT</b> Address<br><b>Mrs. Percy O'Rourk: Mexico, Missouri</b> |  |
|--|--|---|--|---|--|

|   |  |  |                                  |  |  |
|---|--|--|----------------------------------|--|--|
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY: |  |  | INTERVAL BETWEEN ONSET AND DEATH |  |  |
| IMMEDIATE CAUSE (a) <b>Pnuemonia</b>  |  |  |                                  |  |  |
| 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 |  |  |  |

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | <b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/> |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) |  |  |  |
|---|--|--|--|---|--|--|--|

|   |  |                        |  |
|---|--|------------------------|--|
| <b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. |  | Month, Day, Year _____ |  |
|---|--|------------------------|--|

|  |  |   |  |                                     |  |        |  |       |  |
|--|--|---|--|-------------------------------------|--|--------|--|-------|--|
| <b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> |  | <b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | <b>20f. CITY, TOWN, OR LOCATION</b> |  | COUNTY |  | STATE |  |
| <b>General Hospital</b>  |  |   |  |                                     |  |        |  |       |  |

21. I attended the deceased from 11-26-59 to 12-3-59 and last saw her alive on 12-3-59  
 Death occurred at 1:40a on the date stated above, and to the best of my knowledge, from the causes stated.

|   |  |  |   |  |  |   |  |  |
|---|--|--|---|--|--|---|--|--|
| <b>22a. SIGNATURE</b> (Degree or title)<br><i>H.R. Dwyer</i> M.D. |  |  | <b>22b. ADDRESS</b><br><b>2400 Cherry K.C., Mo.</b> |  |  | <b>22c. DATE SIGNED</b><br><b>12-3-59</b> |  |  |
|---|--|--|---|--|--|---|--|--|

|  |  |                                    |  |  |  |   |  |
|--|--|------------------------------------|--|--|--|---|--|
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><b>Removal</b> |  | <b>23b. DATE</b><br><b>12-4-59</b> |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>Peninsula Cemetery</b> |  | <b>23d. LOCATION</b> (City, town, or county) (State)<br><b>Black Water Junction, Missouri</b> |  |
|--|--|------------------------------------|--|--|--|---|--|

|  |  |  |   |  |  |  |  |
|--|--|--|---|--|--|--|--|
| <b>24. FUNERAL DIRECTOR</b> ADDRESS<br><b>WEILERT FUNERAL HOMES(S) K.C., MO.</b> |  |  | <b>25. DATE RECD. BY LOCAL REG.</b><br><b>12-4-59</b> |  | <b>26. REGISTRAR'S SIGNATURE</b><br><i>Alva Marshall</i> |  |  |
|--|--|--|---|--|--|--|--|

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Dwyer

**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 B. E. Wilcox

Licensed Embalmer No. 4075

P. O. Address Rt. 8, M

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.