

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-000474

XC-1741 66 75

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3007

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STATE FILE NUMBER

DEAD FILED VS FEB 8 1960

1. PLACE OF DEATH a. COUNTY <b>BUTLER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>ARKANSAS</b> b. COUNTY <b>SHARP</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>POPLAR BLUFF</b>		c. CITY OR TOWN <b>HARDY</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VA HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>ROUTE # 1</b>

3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>NEWMAN</b> Last <b>NEWMAN</b>			4. DATE OF DEATH Month <b>JANUARY</b> Day <b>3</b> Year <b>1960</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6-12-87</b>	9. AGE (last birthday) <b>72</b>	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>HAGAMAN, NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>AUGUST NEWMAN</b>			13b. MOTHER'S MAIDEN NAME <b>ANNA RICHTER</b>			14. NAME OF HUSBAND OR WIFE <b>None</b>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes</b> <b>WHI</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>No living relatives</b> <b>Friend: Simon O. Norris, Williford, Ark.</b>	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial failure and Uremia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Coronary Arteriosclerotic heart disease with aortic insufficiency &amp; Paroxymal auricular fibrillation &amp; congestive heart failure</b>			Unknown		
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>1. Benign prostatic hypertrophy 2. Bilateral inguinal hernia</b>				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.)	
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	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
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21. I attended the deceased from **Nov 9, 1959** to **January 3, 1960** and last saw him ~~live on~~  
Death occurred at **1:50 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>B. M. GARDNER, M.D. Atty. Chief Surgery</b>	22b. ADDRESS <b>VAH, Poplar Bluff, Mo.</b>	22c. DATE SIGNED <b>1/5/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Jan. 5, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baker Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Williford (Rt.) Ark.</b>
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24. FUNERAL DIRECTOR <b>Higginbotham Funeral Ser, Hardy, Ark.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>1/5/60</b>	26. REGISTRAR'S SIGNATURE <b>[Signature]</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

1961

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 RC Johnson

Licensed Embalmer No. 772

P. O. Address Wichita, KS

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.

*[Handwritten scribbles and marks at the bottom left of the page]*