

JR. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005914

FILED VS FEB 23 1960

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 165 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>HAZLEDE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u>	Length of stay in 1b <u>2 HRS</u>	c. CITY OR TOWN <u>CONWAY, MO.</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>BURGE Hosp.</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES OLLIE NEWMAN</u>			4. DATE OF DEATH Month Day Year <u>FEB 8 1960</u>			
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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>12-17-1881</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET BAKERSMITH</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
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13a. FATHER'S NAME <u>ROBERT NEWMAN</u>	13b. MOTHER'S MAIDEN NAME <u>SARAH ROUTH</u>	14. NAME OF HUSBAND OR WIFE <u>VICTORIA</u>
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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>500-12-9214</u>	17. INFORMANT Address <u>VICTORIA NEWMAN CONWAY MO</u>
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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) <u>Neuro Circulatory Collapse</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Multiple Rib Fractures +</u>	
	DUE TO (c) <u>Fractures of Both Femur.</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	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Struck by Automobile</u>
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20c. TIME OF INJURY Hour a.m. p.m. <u>FEB 8, '60</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>Conway Hazlede MO</u>
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21. I attended the deceased from <u>Feb 8 - 60</u> to <u>Feb 8 - 60</u> and last saw her/him alive on <u>Feb 8 - 1960</u>	
Death occurred at <u>3:40 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>	22b. ADDRESS <u>Springfield, Mo. 450 South St.</u>	22c. DATE SIGNED <u>2/12/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>2-8-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GRAHAM</u>	23d. LOCATION (City, town, or county) (State) <u>DALLAS CO MO</u>
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24. FUNERAL DIRECTOR ADDRESS <u>BARBER-EDWARDS MARSHFIELD</u>	25. DATE RECD. BY LOCAL REG. <u>2-15-60</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>
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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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *R. W. Boorbe*

Licensed Embalmer No. 384

P. O. Address *W. W. Boorbe*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
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.