

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-024833

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 209

FILED AUG 7 1961

1. PLACE OF DEATH
 a. COUNTY Greene
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield Length of stay in lb 3 days
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Johns Hosp Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE Colorado b. COUNTY Denver Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) 7935 Vallejo Reside on Farm Yes No

3. NAME OF DECEASED First Middle Last 4. DATE OF DEATH Month Day Year
Jerlene Mae Newman July-27-1961

5. SEX Female 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 1-9-1924 9. AGE (last birthday) 37 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) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Brookline, Mo 11. BIRTHPLACE (City and state or country) U.S.A. 12. CITIZEN OF WHAT COUNTRY

13a. FATHER'S NAME Hershel O. Batson 13b. MOTHER'S MAIDEN NAME Fula Stigall 14. NAME OF HUSBAND OR WIFE Ray S. Newman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 17 INFORMANT Ray S Newman Denver Colorado Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Cerebral Hemorrhage SUBARACHNOID
 DUE TO (b) _____
 DUE TO (c) _____
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
 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.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 7-24-61 to 7-25-61 and last saw her/him alive on 7-25-61
 Death occurred 7-27-61 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (In green or title) John P. K. Saucy M.D. 22b. ADDRESS 1636 S. Hawthorne Springfield Mo. 22c. DATE SIGNED 7-31-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE 7-30-61 23c. NAME OF CEMETERY OR CREMATORY Moore Cemetery 23d. LOCATION (City, town, or county) (State) Stotts City Mo

24. FUNERAL DIRECTOR Max L. Forest ADDRESS Moore 25. DATE RECD. BY LOCAL REG. 8-3-61 26. REGISTRAR'S SIGNATURE Effie B. Meehan

DATE AMENDED 9/29/61
 INSTEAD OF Cerebral Hemorrhage
 SHOULD READ Subarachnoid Hemorrhage
 ITEM NO. 18a

DOCUMENT BY AFFIDAVIT OF attending physician

MEDICAL CERTIFICATION

AUG 17 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Eric M. Abbott

Licensed Embalmer No. 5115

P. O. Address Springfield, 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.