

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-043248

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 167 Primary Registration District No. 4256 Registrar's No. 48

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 20 1962

1. PLACE OF DEATH a. COUNTY JOHNSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY JOHNSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN HOLDEN		Length of stay in 1b 50 YEARS	c. CITY OR TOWN HOLDEN Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION W. 3rd ST.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) W. 3rd ST. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last BERTHA MAUDE NEWLAND			4. DATE OF DEATH Month Day Year NOVEMBER 7, 1962		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-3-1892	9. AGE (last birthday) 80	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 HOME	11. BIRTHPLACE (City and state or country) DUNNIGAN, CALIFORNIA	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME WILLIAM CHAPPELL		13b. MOTHER'S NAME HELEN BERTHA GRAY		14. NAME OF HUSBAND OR WIFE DR. A.B. NEWLAND	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address DR. A.B. NEWLAND, HOLDEN, MO.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH
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) Arteriosclerosis		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 Month, Day, Year a.m. p.m.		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.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	

21. I attended the deceased from May 1960 to Nov 1962 and last saw her alive on Nov. 6, 1962
Death occurred at 11 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Kelly Rawlin M.F.		22b. ADDRESS Holden MO		22c. DATE SIGNED 11/9/62
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 11-10-1962	23c. NAME OF CEMETERY OR CREMATORY HOLDEN CEMETERY	23d. LOCATION (City, town, or county) HOLDEN, MISSOURI	
24. FUNERAL DIRECTOR ADDRESS CAST FUNERAL HOME, HOLDEN, MO.		25. DATE RECD. BY LOCAL REG. 11-12-62	26. REGISTRAR'S SIGNATURE Bernice Rose	

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

STATE OF MISSOURI
DEPARTMENT OF HEALTH

MISSOURI STATE BOARD OF HEALTH

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x

STATE OF MISSOURI
DEPARTMENT OF HEALTH

STATE OF MISSOURI
DEPARTMENT OF HEALTH

STATE OF MISSOURI
DEPARTMENT OF HEALTH
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 E.B. Cast

Licensed Embalmer No. 4059

P. O. Address Holden, 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.

MISSOURI STATE BOARD OF HEALTH
DEPARTMENT OF HEALTH
STATE OF MISSOURI