

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

15058

1. PLACE OF DEATH

105 County Sullivan  
Township morris  
City (No.)

Registration District No. 857  
Primary Registration District No. 6125

File No. 1  
Registered No. 5  
St. Ward)

2. FULL NAME

Sarah M. Newton

(a) Residence. No. St. Ward.  
(Usual place of abode)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX. Female  
4. COLOR OR RACE white  
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

John Newton

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June-15-1851

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
80 10 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work housewife  
(b) General nature of industry, business, or establishment in which employed (or employer) on farm  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Ohio 28

PARENTS

10. NAME OF FATHER Thomas Farrow

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ireland 15  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Esther Fairbrother

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) England 8  
(STATE OR COUNTRY)

14.

INFORMANT Mrs. John R. Graham  
(Address) Green City MO

15.

FILED 4-25 1932 Ben Thompson

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-13- 1932

17. I HEREBY CERTIFY, That I attended deceased from 1 26 1932, to 11-13- 1932, that I last saw her alive on Mar 13 1932 and that death occurred, on the date stated above, at 8/a m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Carcinoma of the uterus

CONTRIBUTORY (SECONDARY)

48 (duration) Dont know yrs. mos. ds.

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Ross H. Shepler, M. D.

, 19 (Address) Green City Mo.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Fair View Cem

4/17- 1932

20. UNDERTAKER

ADDRESS

Glenn E. Trent

Green City

