

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

Do not use this space.

37129

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Russ Primary Registration District No. 1002
City N.C. Mo. (No. 2911 East 30th) St. _____ Ward _____

File No. 4598
Registered No. _____
St. _____ Ward _____

2. FULL NAME John James Newell

(a) Residence No. 2911 E - 30th St. 14 Ward _____

(Usual place of abode) (If nonresident, give city or town and State)
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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Divorced

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan - 3 - 1867

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
62 10 3

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

10. NAME OF FATHER no record

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) no record

12. MAIDEN NAME OF MOTHER no record

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) no record

14. INFORMANT Margaret Chesser (Address) 2911 E - 30th

15. FILED 11/7 19 29 M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov - 6 - 1929

17. I HEREBY CERTIFY, That I attended deceased from Nov 2, 1929, to Nov 6, 1929 that I last saw him alive on Nov 6, 1929 and that death occurred, on the date stated above, at 11:00 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

severe coronary artery disease
10-15 (duration) yrs. mos. ds.
10-0 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) bronchitis (duration) yrs. mos. ds. 7

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF BIRTH _____

DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS stained smears

(Signed) [Signature] M. D.

2177, 1929 (Address) 715 Maple Blv.

*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

Forest Hill 11-7-29

20. UNDERTAKER ADDRESS

Mrs. C. L. Foster N.C. Mo.

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.

639
2
31

Page 11