

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

Do not use this space.

1. PLACE OF DEATH

County Callaway Registration District No. 104
 Township Primary Registration District No. 3008
 City Fulton (No., St., Ward)

File No. 15940
 Registered No. 100

2. FULL NAME

Zach T. Newell
 (a) Residence, No. State Hosp #1 St. Ward.
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 3 yrs. 11 mos. 5 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) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. Z. T. Newell
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Don't know
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
52 yrs.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. farmer
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

FATHER 13. NAME DK

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) DK

MOTHER 15. MAIDEN NAME DK

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) DK

17. INFORMANT (ADDRESS) Records State Hosp #1

18. BURIAL, CREMATION, OR REMOVAL PLACE Unionville Mo DATE May 10 1934

19. UNDERTAKER (ADDRESS) Geo. H. Wallace Fulton Mo

20. FILED May 8 1934 R. M. Creech Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-8 1934
 22. I HEREBY CERTIFY, That I attended deceased from June 7 1933 to May 8 1934
 I last saw him alive on May 7 1934 Death is said to have occurred on the date stated above, at 5:35 A.M.
 The principal cause of death and related causes of importance were as follows:

Paralysis agitans
(P. det. encephalitis)
87B
93D
 Other contributory causes of importance:
Myocardial deficiency
Hypostatic pneumonia
 Date of onset 14 yrs.

Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury 19.....
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify
 (Signed) T. S. Lapp, M. D.
 (Address) Fulton, 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.

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DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

WASHINGTON 15940

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

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Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Zack T. Newell
Who died at _____ on May - 8 - 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex M Color or race W Single, married, widowed or divorced: _____
Date of birth _____ Age: Years 52 Months _____ Days _____

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

Date deceased last worked at this occupation: Month _____ Year 78
Birthplace (State or country) _____
Birthplace of father (State or country) _____
Birthplace of mother (State or country) _____
Principal cause of death: Paralysis agitans (Post Encephalitis)
Was not Epidemic Encephalitis

Other contributory causes of importance _____
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19 _____
where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.
Manner of injury _____
Nature of injury _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
Name of physician _____
Address of physician _____

X Signature of Registrar R. N. Crews - Registrar

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

Reg. Dist. No. 104
Primary Reg. Dist. No. 3008

E. T. McGaugh
Special Agent. mk

RECEIVED

COMMUNICATIONS SECTION

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