

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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

9464
Do not use this space.

REC'D APR 17 1939

1. PLACE OF DEATH

(a) County Jackson County Mo. Registration District No. 399
 (b) Township Rau Primary Registration District No. 1002 Registered No. 1070
 (c) City Kansas City Mo. (d) Street No. 5331 Highland Ave St.
 (If death occurred in Hospital or institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred 3 yrs. 4 mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT-FULL NAME Theodora Newbway

(a) Residence, No. 5331 Highland Ave (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 10th 1852

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>85</u>		<u>2</u>	<u>27</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None

9. Industry or business in which work was done, as 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) Unknown

FATHER

13. NAME Robert Newbway

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No RECORD

MOTHER

15. MAIDEN NAME Margaret Fontleroy

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No RECORD

17. INFORMANT Sister Camille Sup.
(ADDRESS) 5331 Highland Ave

18. BURIAL, CREMATION, OR REMOVAL
PLACE MT. CAVARY DATE 3/9/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) 2418 N. W. TOBIN CO. KANSAS CITY, MO.

20. FILED Mo. 39 M. M. Croome
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 7th 1939

22. I HEREBY CERTIFY, That I attended deceased from Sept 12, 1936, to March 7, 1939
 I last saw him alive on March 3, 1939 Death is said to have occurred on the date stated above, at 8 a. m.
 The principal cause of death and related causes of importance were as follows:
Cerebral hemorrhage
82 at 3 days
 Other contributory causes of importance:
Arteriosclerosis
 Name of operation none 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? _____
 If so, specify _____
 (Signed) Paul V. Orourke, M. D.
 (Address) 1402 Bryant Bldg

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.