

EP 25 1940

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

Do not use this space.

29904

## 1. PLACE OF DEATH

County.....Stone...... Registration District No.....1033.  
Township.....Pine...... Primary Registration District No.....6113.  
City.....(No. 0)..... St. .... Ward)

File No.....

Registered No.....

2. FULL NAME 550 Calverna Newman.

(a) Residence, No.....St., .....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 Female. 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 Z. A. Newman.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 27, 1884.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
56 4 13

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife.

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) Blue Eye, Mo.  
(STATE OR COUNTRY)

13. NAME James L. Butler

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

15. MAIDEN NAME Theodora E. Davis.

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

17. INFORMANT Lella Davis  
(ADDRESS) Reeds Spring, Mo.

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Blue Eye Cemetery DATE 8/15 1940

19. UNDERTAKER Nelson Funeral Home  
(ADDRESS) Buyville, Ark.

20. FILED 8/15 1940 Chester D. Scott  
Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 10, 1940

22. I HEREBY CERTIFY, That I attended deceased from  
....., 19....., to....., 19.....

I last saw h..... alive on....., 19..... Death is said  
to have occurred on the date stated above, at 8 P. a.m.

The principal cause of death and related causes of importance were as follows:

"Unknown" (sudden death)

Date of onset

Other contributory causes of importance: 194

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

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) O. E. Miller..... M. D.

(Address) Blue Eye, Mo.

RECEIVED

District Health Officer No. 6,

District File Number 940-2583

Date Filed SEP 12 1940

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **29904**

Registration District No. **1033**

Primary Registration District No. **6113**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Stone  
(b) City or town Stone, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Caluerna Newman

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 56 Months 4 Days 13 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 8/15/40 (b) Chester D. Scott (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stone  
(c) City or town Rural  
(If outside city or town limits write "RURAL")  
(d) Street No. 1/4 mi. N. East Blue Eye, Mo.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? Born in Missouri years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 10 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature C. E. Miller (M. D. or other) \_\_\_\_\_

Address Blue Eye no signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

8115-40

