

No. 2  
4-13-40  
5-17-39  
I X23139

APR 12 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

14071

State File No. ....

Registration District No. 104

Primary Registration District No. 3008

Registrar's No. 104

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

1. PLACE OF DEATH

(a) County Callaway

(b) City or town Callaway

(c) Name of hospital or institution: State Hospital # 13  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Christian <sup>14</sup>

(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL") <sup>1</sup>

(d) Street in State Pen. & State Hospital for part  
7 years (If rural, give location) <sup>2</sup>

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME JAMES NEWTON

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. D K

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. day 3 year 1941 hour 3 minute 45 A.M.

4. Sex Male 5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Glorena Newton

6. (c) Age of husband or wife if alive D.K. years

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

21. I hereby certify that I attended the deceased from May, 1940, to Apr. 3, 1941; that I last saw him alive on Apr. 9, 1941; and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

about 60 hr. min.

Immediate cause of death Chronic Myocarditis

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

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

Due to \_\_\_\_\_ 92H

Other conditions (include pregnancy within 3 months of death)

10. Usual occupation D.K.

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

11. Industry or business D.K.

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

12. Name D.K.

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

14. Maiden name D.K.

15. Birthplace D.K. 4  
(City, town, or county) (State or foreign country)

16. (a) Informant State Hospital record

17. (a) Removal (b) Date thereof 4-7-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director Columbia MO  
J. O. Roberts  
Columbia MO

19. (a) April 7, 1941 (b) R. N. Creve  
(Date received local registrar) (Registrar's signature)

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? NO  
(Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature R. N. Creve (M. D. or other) 0  
Address Callaway MO Date signed 4/4/41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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**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, fact should be so stated above.**