

FILLED JUL 17 1941

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

Do not use this space.

21406

1. PLACE OF DEATH

County Christian  
Township Chadwick, 26  
City Chadwick (No. 1)

Registration District No. 186  
Primary Registration District No. 526 1A

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

Methious Leaborn Newton

(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 1 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. 0 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 28-1857  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 84 2 10  
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. retired  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Merchant  
10. Date deceased last worked at this occupation (month and year) 1932 11. Total time (years) spent in this occupation life

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 7, 1941  
22. I HEREBY CERTIFY, That I attended deceased from June 6, 1941, to June 7, 1941  
I last saw him alive on June 7, 1941 Death is said to have occurred on the date stated above, at 6 p. m.  
The principal cause of death and related causes of importance were as follows:

Pneumonia  
Degener. heart dis.

Date of onset probably 6-7-40

Other contributory causes of importance:  
Degener. heart disease

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arkansas  
13. NAME John J. Newton  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mississippi  
15. MAIDEN NAME Eliza Walker  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Alabama

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

17. INFORMANT Alma Newton (ADDRESS) Chadwick, Mo.  
18. BURIAL, CREMATION, OR REMOVAL PLACE Chadwick DATE 6-8 1941  
19. UNDERTAKER John Harris (ADDRESS) Chadwick, Mo.  
20. FILED 7-9-41 1941. Ina Jones Registrar.

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) S. L. Roper M. D.  
Chadwick, Mo. (Address)

97A

RECEIVED

District Health Officer No. 6,

District File Number 741-1245

Date Filed JUL 16 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 21406

Registration District No. 186

Primary Registration District No. 2261A

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

1. PLACE OF DEATH:

(a) County Christian  
(b) City or town Chadwick T.P.  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Methuous Seaborn Newton

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

4. Sex M 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 \_\_\_\_\_ year \_\_\_\_\_

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

8. AGE: Years Months Days If less than one year  
84 2 10 or \_\_\_\_\_ min.

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

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

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

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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

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

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH. Month June day 7  
year 1941 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 Pneumonia Duration \_\_\_\_\_  
2 1/2

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

Due to Digen. Heart disease

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

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

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature S. D. Royer (M. D. or other) \_\_\_\_\_

Address Dark Date signed \_\_\_\_\_

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

SUPPLEMENTAL ENTRY

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 21406

Registration District No. 186

Primary Registration District No. 5261

Registrar's No.

1. PLACE OF DEATH:

(a) County Christian  
(b) City or town Chadwick Twp  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town Chadwick Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Melvin Seaborn Newborn  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month June day 7  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex M 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 Months Days If less than one day  
84 2 10 hr \_\_\_\_\_ min \_\_\_\_\_

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

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

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

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) Aug. 11<sup>th</sup> 1941 (b) Ina Jones  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
Duration  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions: (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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? \_\_\_\_\_

While at work? (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature S. D. Poyer (M. D. or other) \_\_\_\_\_

Address Ozark Mo Date signed \_\_\_\_\_

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

SUPPLEMENTAL