DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 10 1942

Registration District No. 85

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1754

Primary Registration District No. 1001

Registrar's No. 39

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

1. PLACE OF DEATH:
(a) County: Buchanan,
(b) City or town: Saint Joseph, (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri Methodist Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 30 days, (Specify whether years, months or days)
In this community 6 months

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri, (b) County: Buchanan
(c) City or town: Saint Joseph, (If outside city or town limits, write "RURAL")
(d) Street No.: 2746 Penn Street, (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Etta Mae Newman
3. (b) If veteran, name war: None
3. (c) Social Security No.: None
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married,
6. (b) Name of husband or wife: Frank Newman,
6. (c) Age of husband or wife if alive: 62 years
7. Birth date of deceased: May (Month) 1 (Day) 1886 (Year)

8. AGE: Years	Months	Days	If less than one day
55	8	9	hr. min.

9. Birthplace: Lincoln (City, town, or county) Nebraska (State or foreign country)
10. Usual occupation: At Home
11. Industry or business:
FATHER 12. Name: Joseph M. Mooney
13. Birthplace: Concord (City, town, or county) New Hampshire (State or foreign country)
MOTHER 14. Maiden name: Anna Laura Mappleback
15. Birthplace: Halifax (City, town, or county) Nova Scotia (State or foreign country)
16. (a) Informant: Frank Newman
(b) Address: 2746 Penn Street
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 1-12-42 (Month) (Day) (Year)
(c) Place: burial or cremation: Denver, Colorado
18. (a) Signature of funeral director: Heaton-Pr Gole Bowman Funeral
(b) Address: 319 So. 10th. Street, Hand
19. (a) Jan. 12, 1942 (Date received local registrar) (b) W. J. Wallbank (Registrar's signature) M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 10th. year 1942 hour 6:00 minute 45 a.m.

21. I hereby certify that I attended the deceased from Jan 11, 1941, to Jan 10 1942 that I last saw him alive on Jan 9 1942 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Dry arrest	
Due to Gen. metastatic carcinoma of Peritoneum liver etc	
Due to carcinoma of ovary	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations: Carcinomatosis of Peritoneum etc.	
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature: H. Wallbank M.D. (M. D. or other)
Address: 301 N. 8 St. Saint Joseph Mo. Date signed Jan 12 1942

(Licensed Embalmer's Statement on Reverse Side) ST. JOSEPH

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 1-10-

....., Registered Apprentice No.....

working under my personal supervision.

Signed Wm E. Summerfield

Licensed Embalmer No. 3807

P. O. Address 319 So 10 St Smyrna

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

U. S. No. 2B
10M—8-21-41
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State File No. 1754

Registration District No. 85 Primary Registration District No. 1001 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph
(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 years, months or days)
In this community

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 Etta M. Newman
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
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 May (Month) 1 (Day) 1886 (Year)

8. AGE: Years 55 Months 8 Days 8 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan 10 day year 1942 hour minute M.
21. I hereby certify that I attended the deceased from 19 , 19 ; that I last saw him alive on 19 ; and that death occurred on the date and hour stated above.

Duration

Immediate cause of death
Carcinoma of Ovary
Due to See attached letter.
Due to
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature H K Wallace (M. D. or other) MD
Address 301 N 8 St Forsyth Mo Date signed

SUPPLEMENTARY

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