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LED NOV 12 1943

State File No.

Registration District No. 324

Primary Registration District No. 3072

Registrar's No. 210

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Marshall
(c) Name of hospital or institution:
303 N. Miami Ave
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 20 yr years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline?
(c) City or town Marshall
(If outside city or town limits, write "RURAL")
(d) Street No. 303 N. Miami Ave
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME JOHN (Jack) 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 Single

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 hr. min.

9. Birthplace New York City N.Y. (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown
13. Birthplace Unknown 9 (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown 9 (City, town, or county) (State or foreign country)

16. (a) Informant John Reed
(b) Address Marshall Mo

17. (a) Burial (b) Date thereof Oct. 23-1943
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Ridge Park Cem. Marshall Mo

18. (a) Signature of funeral director Harry Herzberger
(b) Address Marshall Mo

19. (a) Oct 22-43 (b) Mo S. O. Wenthore
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 21 year 1943 hour 10 minute P.M.

21. I hereby certify that I attended the deceased from Investigated Oct. 22 1943 that I last saw him alive on _____ 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Suicide by
strychnine sulfate
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) 163 E

Major findings: Of operations _____
Of autopsy Yes -

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Suicide
(b) Date of occurrence Oct. - 21, 1943
(c) Where did injury occur? Marshall Saline Mo
(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 A. L. Kavelas Saline Mo
Address Ridge Park Mo Date signed 10-22-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED
District Health Officer No. 8,
District File Number _____
Date Filed 11-10-43

DECEMBER 14 1943
OFFICE OF THE DISTRICT HEALTH OFFICER
D.C.

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 Harry E. Hershberger
Licensed Embalmer No. 4357
P. O. Address Marshall M

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *Nov.*

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County *Delaware*
 (b) City or town *Marshall*
(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 *30 yr.* years, months or days) (Specify whether

3. (a) PRINT FULL NAME *John (Jack) Newton*

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

4. Sex *m* 5. Color or race *w*

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased *April 15 1871*
(Month) (Day) (Year)

8. AGE: Years *66* Months *6* Days *10* (If less than one day, state in minutes)

9. Birthplace *Newark City N. J.*
(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) *Nov. 6, 1943* (b) *Mrs. T. O. Weathers*
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Oct* day *9*
 year *1943* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
 that I last saw him/her alive on _____, 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Duration

Due to _____

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? _____

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

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKES PERMANENT RECORD

SUPPLEMENTARY

35895