

1. PLACE OF DEATH:

(a) County Polk  
(b) City or town Aldrich Union Day  
(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) 1  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 15 MONTHS (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME M. J. ZEPHIA DELU NEWTON  
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 WIDOW  
6. (b) Name of husband or wife SYLVIA NEWTON 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased MAY 19 1861  
(Month) (Day) (Year)

8. AGE: Years 84 Months 0 Days 6 If less than one day  
hr. min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business

MOTHER FATHER  
12. Name LUTHERY CHAPMAN  
13. Birthplace NOT KNOWN  
(City, town, or county) (State or foreign country)  
14. Maiden name NOT KNOWN  
15. Birthplace NOT KNOWN  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. S. Jones

(b) Address ALDRICH MO.

17. (a) BURIAL (b) Date thereof MAY 27-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MANFIELD MO

18. (a) Signature of funeral director Geo. Steffe

(b) Address MANFIELD MO.

19. (a) 4-23-45 (b) Rose Stewart  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 25  
year 1945 hour 3 minute A. M.

21. I hereby certify that I attended the deceased from Jan last  
1945 to Mar 23, 1945  
that I last saw her alive on MAR 23  
and that death occurred on the date and hour stated above.

Immediate cause of death..... Duration  
Chronic Myocarditis pts.

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) Means of injury.....

23. Signature D. E. F. Wilson (M.D. or other) DO  
Address Fair Play MO Date signed 3/24/45

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

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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.....

*J.A. Steffe*

Licensed Embalmer No. 3221

P. O. Address.....

*Manfield Mo.*

**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.**