

FILED JUN 11 1945

Registration District No. 150

Primary Registration District No. 3127

Registrar's No. 50

1. PLACE OF DEATH:

(a) County Jasper  
(b) City or town Webb City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Jane Chinn Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 47 years (Specify whether years, months or days)  
In this community 47 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper  
(c) City or town Carthage  
(If outside city or town limits, write "RURAL")  
(d) Street No. Chestnut & Howard Sts.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country - - -

3. (a) PRINT FULL NAME

Katie Franklin Newton

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Edward W. Newton 6. (c) Age of husband or wife if alive - - years  
7. Birth date of deceased November 17 1859  
(Month) (Day) (Year)

8. AGE: Years 94 Months 5 Days 15 If less than one day hr. min.

9. Birthplace Cowelsville New York /  
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business None

MOTHER FATHER { 12. Name Daniel Franklin  
13. Birthplace Bannington New York /  
(City, town, or county) (State or foreign country)  
14. Maiden name Anner Veeder  
15. Birthplace Saratogo New York /  
(City, town, or county) (State or foreign country)

16. (a) Informant Frank B. Newton

(b) Address Joplin, Missouri

17. (a) Burial (b) Date thereof May 4, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park Cemetery

18. (a) Signature of funeral director Knell Mortuary

(b) Address Carthage, Missouri

19. (a) May 4, 1945 (b) Mrs. Helia Legle  
(Date reported to registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 9 year 1945 hour 9 minute P. M.

21. I hereby certify that I attended the deceased from 1945 to May 2, 1945  
that I last saw her alive on May 2, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Chromic fibroid myocar. ditis

Due to Arterio-sclerosis

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

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

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 R. M. Stormont (M. D. or other)  
Address Webb City, Mo. Date signed 5/4/45

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

19  
6  
L

1180

45-5-437

---

---

**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 Emm R. Kneef

Licensed Embalmer No. 391

P. O. Address Carthage

**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.**