

S. No. 2  
 FORM-5-43  
 rev. 5-17-39  
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DEPARTMENT OF HEALTH  
 BUREAU OF THE CENSUS  
**FILED FEB 5 1947**

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

State File No. **1466**  
 Registrar's No. **10**

Registration District No. **150**

Primary Registration District No. **5573**

**1. PLACE OF DEATH:**  
 (a) County **JACKSON**  
 (b) City or town **OAK GROVE (RURAL) SNI-BAR**  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
**HOME OF H. P. MORRISON**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **12 YEARS**  
 (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State **MISSOURI** (b) County **JACKSON**  
 (c) City or town **OAK GROVE (RURAL) SNI-BAR**  
 (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** **MRS. JANE NEWTON**  
 (b) If veteran, **NO** name war \_\_\_\_\_  
 (c) Social Security No. **NO**

4. Sex **FEMALE** 5. Color or race **WHITE**  
 6. (a) Single, widowed, married, divorced **WIDOWED**  
 6. (b) Name of husband or wife **HIRAM B. NEWTON**  
 6. (c) Age of husband or wife if alive **XXXXXX** years  
 7. Birth date of deceased **6 9 1849**  
 (Month) (Day) (Year)

**8. AGE:** Years **97** Months **7** Days **11**  
 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

**9. Birthplace** **BROOME COUNTY CANADA**  
 (City, town, or county) (State or foreign country)

**10. Usual occupation** **NONE**  
**11. Industry or business** **NONE**

**12. Name** **JOSHUA COOK**  
**13. Birthplace** **XXXXXXXX CANADA**  
 (City, town, or county) (State or foreign country)

**14. Maiden name** **PAMELIA SHEUFELD**  
**15. Birthplace** **XXXXXXXX CANADA**  
 (City, town, or county) (State or foreign country)

**16. (a) Informant** **MISS PEARL F. NEWTON**  
 (b) Address **OAK GROVE MISSOURI**

**17. (a) REMOVAL** (Burial, cremation, or removal) (b) Date thereof **1-22-47**  
 (Month) (Day) (Year)  
 (c) Place: burial or cremation **PLANO, ILLINOIS**

**18. (a) Signature of funeral director** *Henry W. Stahl*  
 (b) Address **815 W. MAPLE, INDEPENDENCE MO.**

**19. (a) JAN. 21, 1947** (Date received local registrar) (b) *Donald C. Emswiler* (Registrar's signature)

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month **1** day **20**  
 year **1947** hour **2** minute **30** A. M.  
**21. I hereby certify that I attended the deceased from**  
**December 12, 1943** to **January 20, 1947**  
 that I last saw him alive on **January 20, 1947**  
 and that death occurred on the date and hour stated above.

Immediate cause of death: **Myocardial failure** Duration **1 hour**  
**Coronary thrombosis** Duration **1 hour**  
**Senility and coronary sclerosis** Duration **3 yrs.**  
 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.  
*947*

**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** *R. E. Hawes* (M. D. or other) **DO.**  
 Address **Oak Grove Mo** Date signed **1-20-47**

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, ~~by~~.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Henry W. Stahl.....

Licensed Embalmer No. 3181.....

P. O. Address Independence 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.**