

S. No. 2
12-45
5-17-39
K47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1253

State File No.

FILED FEB 7 1948

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 393

1. PLACE OF DEATH:

(a) County JACKSON
(b) City or town KANSAS CITY
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
KCTB HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 27 days
(Specify whether
In this community 49 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON
(c) City or town KANSAS CITY
(If outside city or town limits, write "RURAL")
(d) Street No. 22 East 31st
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME NEWHOUSE, Robert Oscar.

3. (b) If veteran, name war No 3. (c) Social Security No. 486-09-3620

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed

(b) Name of husband or wife Juaneta Newhouse 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: Jan 13 1981
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 0 13 hr. min.

9. Birthplace Jefferson City Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Brewery Emp.

11. Industry or business

12. Name NEWHOUSE, Ben.

13. Birthplace INDIANA
(City, town, or county) (State or foreign country)

14. Maiden name RENFRO, ?

15. Birthplace MISSOURI
(City, town, or county) (State or foreign country)

16. (a) Informant KCTB HOSP.

(b) Address KANSAS CITY

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/48
(Month) (Day) (Year)

(c) Place: burial or cremation Fairview Cemetery

18. (a) Signature of funeral director Paul W. Cobin

(b) Address 20 N. Dunwood

19. (a) 1-28-48 (Date received local registrar) (b) Theraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 26
year 1948 hour 2 15 minute PM M.

21. I hereby certify that I attended the deceased from 12 21 31, 1947, to 1-26, 1948
that I last saw him alive on 1-26, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration 4 Mo.

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: 138

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? (1)

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

23. Signature William David May (M. D. or other M.D.)

Address K.C. 3, Mo. Date signed 1-26-48

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

MOTHER FATHER

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..... *Howard W. Farmer*.....
Licensed Embalmer No. *4134*.....
P. O. Address *Kansas City 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.