No. 300
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30048

FILED SEP 17 1948

Registration District No. 946

Primary Registration District No. 3026

Registrar's No. 262

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

1. PLACE OF DEATH:

(a) County Jackson Co.

(b) City or town Independence Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Independence Sanitarium
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days (Specify whether
In this community 64 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 502 So. Van Brunt
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME WILLIAM F. NEWTON

3. (b) If veteran, name war -

3. (c) Social Security No. -

4. Sex male 0

5. Color or race white

6. (a) Single, widowed, married, divorced mar. 1

6. (b) Name of husband or wife Hilda Christine

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased August 26 1884
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
64	0	7	hr. min.

9. Birthplace Jackson Co. (City, town, or county) Mo. (State or foreign country) 0

10. Usual occupation Dentist

11. Industry or business Self

FATHER
12. Name Samuel S. Newton
13. Birthplace (City, town, or county) England (State or foreign country) 7

MOTHER
14. Maiden name Sarah Muncie
15. Birthplace (City, town, or county) Iowa (State or foreign country) 1

16. (a) Informant Hilda Christine Newton
(b) Address 502 So. Van Brunt

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-4-1948 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director C. H. Blackman & Son, Inc.
(b) Address 2825 Independence Blvd.

19. (a) 9-4-48 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 2
year 1948 hour 6 minute 32 P.M.

21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Shock
Fracture of Ankle,
Due to Ribs & Vertebra
Due to Auto Trauma
Other conditions (Include pregnancy within 3 months of death) Deputy Coroner

Major findings:
Of operations
Of autopsy See Above

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) Accident
(b) Date of occurrence 8-27-48
(c) Where did injury occur? Independence Mo (City or town) (County) (State)
(d) Did injury occur in or about home, in farm, in industrial place, in public place?
(Specify type of place)
While at work? No (e) Means of injury Trauma

23. Signature A. E. Upsher (M. D. or other) MD
Address 2800 Main Date signed 9/5/48

(Licensed Embalmer's Statement on Reverse Side)

(Pedestrian STP)

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 O K McFarland

Licensed Embalmer No. 4397

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.