

FILED DEC 17 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41244**
5232

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) Clinton	
c. LENGTH OF STAY (In this place) 2 days		d. STREET ADDRESS (If rural, give location) Kansas City - Plattsburg	
d. FULL NAME OF HOSPITAL OR INSTITUTION: General Hospital No. 1		e. STREET ADDRESS (If rural, give location) 5517 Agnes	

3. NAME OF DECEASED (Type or Print)	a. (First) William	b. (Middle) S.	c. (Last) Newman	4. DATE OF DEATH (Month) 12 (Day) 8 (Year) 1949
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 9-27-1865	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Marion F. Newman	13b. MOTHER'S MAIDEN NAME Elvira White	14. NAME OF HUSBAND OR WIFE Hannah Newman
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) X	16. SOCIAL SECURITY NO. X	17. INFORMANT'S SIGNATURE OR NAME Clayton Newman, 5517 Agnes	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular accident		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT (Specify) SUICIDE	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Dec. 6, 1949**, to **Dec. 8, 1949**, that I last saw the deceased alive on **Dec. 8, 1949**, and that death occurred at **5:50 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE Wm. W. Hart (Degree or title)	23b. ADDRESS Med. Dir. Gen'l Hosp.	23c. DATE SIGNED 12-9-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 12-10-49	24c. NAME OF CEMETERY OR CREMATORY -	24d. LOCATION (City, town, or county) (State) Plattsburg Missouri
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DATE REC'D BY LOCAL REG. 12-10-49	REGISTRAR'S SIGNATURE Steraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE Stine & McClure,	ADDRESS K.C. Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

Mr. [unclear]

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Joseph M. Carthy*

Licensed Embalmer No. *4694*

P. O. Address. *R.C. 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.