

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16801**

FILED JUN 7 1952

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 1869

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Clinton	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Plattsburg	
c. LENGTH OF STAY (In this place) 1 day		d. STREET ADDRESS (If rural, give location) X	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) NEWTON	b. (Middle) H.	c. (Last) TABB	4. DATE OF DEATH (Month) (Day) (Year) April 19, 1952
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5. SEX M.	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH January 17, 1871	9. AGE (In years last birthday) 81	# UNDER 1 YEAR Months	# UNDER 1 YEAR Days	# UNDER 1 YEAR Hours	# UNDER 1 YEAR Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Kentucky	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME John L. Tabb	13b. MOTHER'S MAIDEN NAME Mary Jane Cushman	14. NAME OF HUSBAND OR WIFE Kate Tabb
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service) No	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME Mrs. Roxye Underwood Galloway	ADDRESS Parkville, Mo.
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Medication of brain		INTERVAL BETWEEN ONSET AND DEATH 2 days
	ANTECEDENT CAUSES Subdural hematoma		
	DUE TO (b) Falling and hitting head against hard object		
DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			5/4

19a. DATE OF OPERATION Apr 19-52	19b. MAJOR FINDINGS OF OPERATION As above	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT (Specify) Street	21b. PLACE OF INJURY (e.g., in or about home, factory, street, office bldg., etc.) Street	21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) Plattsburg Clinton Mo
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 4-17-52	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Patient fell on street
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I hereby certify that I attended the deceased from **14th April 1952**, that I last saw the deceased alive on **Apr 19 1952**, and that death occurred at _____ m., from the causes and on the date stated above.

22a. SIGNATURE Roxye Underwood (Degree or title) MD	22b. ADDRESS 1600 Prof Bldg, KCMO	22c. DATE SIGNED May 27 1952
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 4/23/52	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. 4-23-52	REGISTRAR'S SIGNATURE Verallina Holmes	25. FUNERAL DIRECTOR'S SIGNATURE STINE & McCLURE	ADDRESS Kansas City, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

MAY 6 1955

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

John Clark

Licensed Embalmer No. 4216

P. O. Address K. 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.