

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

7407

FILED MAR 11 1957

STATE FILE NUMBER

Registration District No. 373 Primary Registration District No. 4544 Registrar's No. 12

1. PLACE OF DEATH a. COUNTY <u>WEBSTER</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>WEBSTER</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>VIANGUA</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>VIANGUA MO</u> <sup>1120</sup>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Length of stay in 1b		d. STREET ADDRESS (If outside, give location)			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>KENTON</u> Middle <u>RAY</u> Last <u>NEWTON</u>				4. DATE OF DEATH Month <u>3</u> Day <u>3</u> Year <u>57</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-12-55</u>		9. AGE (In years last birthday) <u>2</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>WILBUR NEWTON</u>				14. MOTHER'S MAIDEN NAME <u>VINATA J. VIANGUA MO</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT Address <u>WILBUR NEWTON, VIANGUA, MO</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute ependymitis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Obstructive non communicating hydrocephalus</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 d.</u> <u>2 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>						
20c. TIME OF INJURY Hour <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>  </u> a. m. <u>  </u> p. m. <u>  </u>								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. CITY, TOWN, OR LOCATION <u>  </u>		COUNTY <u>  </u>		STATE <u>  </u>
21. I attended the deceased from <u>3-1-57</u> to <u>3-3-57</u> and last saw <sup>her</sup> him alive on <u>3-1-57</u> Death occurred at <u>3</u> P. m. on the date stated above; and to the best of my knowledge, from the cause stated.								
22a. SIGNATURE (Degree or title) <u>Urban Busch MD</u>				22b. ADDRESS <u>609 Cherry Springfield</u>		22c. DATE SIGNED <u>3-6-57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>3-3-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Prospect</u>		23d. LOCATION (City, town, or county) (State) <u>EAST of VIANGUA, MO</u>			
24. FUNERAL DIRECTOR <u>BARBER-EDWARDS</u>		ADDRESS <u>Marshfield</u>		25. DATE RECD. BY LOCAL REG. <u>3/8/57</u>		26. REGISTRAR'S SIGNATURE <u>  </u>		

Doctor, coroner, etc. must use any standard nomenclature in name of the symptoms with or without "All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes."

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

920

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.....  
Signature of Student Embalmer

Signed.....  
*R. W. B. [Signature]*

Licensed Embalmer No. 3

P. O. Address *Wm. Brown*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.