

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-024433

STATE FILE NUMBER

FILED VS JUL 21 1959

Registration District No. 387 Primary Registration District No. 5207 Registrar's No. 9

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Carroll	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Dawn		c. CITY OR TOWN Dawn	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Home.		d. STREET ADDRESS (If outside, give location) 4 1/2 Mile S/W BlueMound	
Length of stay in lb 35 years		Reside on Farm <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	

3. NAME OF DECEASED (Type or print) First ELLA Middle MAE Last NEWMAN	4. DATE OF DEATH Month July Day 15th Year 1959
---	--

5. SEX F	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 23, 1871	9. AGE (In years last birthday) 87	IF UNDER 1 YEAR Months 7 Days 22	IF UNDER 24 HRS. Hours Min.
-----------------	-------------------------------	---	--	--	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farm wife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Des Moines, Iowa.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	-----------------------------------	--	---

13a. FATHER'S NAME John Collins,	13b. MOTHER'S MAIDEN NAME Emma ??	14. NAME OF HUSBAND OR WIFE Frank Newman
--	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no no none	16. SOCIAL SECURITY NO.	17. INFORMANT Troy Gilbert, Dawn, Missouri.	Address
--	-------------------------	---	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH ?
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Atherosclerosis		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hypertension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) H43X
---	---

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. 	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
---	--	------------------------------	--------	-------

20d. INJURY OCCURRED WHILE AT <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.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
---	--	------------------------------	--------	-------

21. I attended the deceased from 6-28-59 to 7-15-59 and last saw her alive on 6-28-59.
Death occurred at 1:30 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Joseph F. Gale M.D.	22b. ADDRESS Chillicothe Mo	22c. DATE SIGNED 7-17-59
--	---------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7/17/1959	23c. NAME OF CEMETERY OR CREMATORY New Salem Cemetery	23d. LOCATION (City, town, or county) (State) Tina, Missouri.
--	-------------------------------	---	---

24. FUNERAL DIRECTOR Clifford W. Austin Tina, Missouri	25. DATE RECD. BY LOCAL REG. July 17, 1959	26. REGISTRAR'S SIGNATURE Mrs. Rex Henderson
--	--	--

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Clifford W. Austin*
Clifford W. Austin,

Licensed Embalmer No. #3233

P. O. Address..... Tina, Missouri

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.