URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-035447

STATE FILE NUMBER

ILED VS SEP 26 1960

NDED

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 168

1. PLACE OF DEATH
a. COUNTY Livingston
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Chillicothe — Length of stay in 1b 2½ years
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Susans Rest Home 505 2nd St. — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Livingston
c. CITY OR TOWN Chillicothe R#5 — Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) 3 mi So - 2 mi West Chula. — Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First Lovetta Middle Last Newton

4. DATE OF DEATH Month September Day 15 Year 1960

5. SEX Female
6. COLOR OR RACE White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH June 21 1882
9. AGE (last birthday) 78 — IF UNDER 1 YEAR Months 2 Days 24 — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (City and state or country) Everson Ville Mo
12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Henderson Dust
13b. MOTHER'S MAIDEN NAME Pollyana Reuark.
14. NAME OF HUSBAND OR WIFE John Newton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT X Mrs Jimmie Graham Address Chillicothe

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia Terminal, Bronchial — INTERVAL BETWEEN ONSET AND DEATH 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cerebral Hemorrhage — 4 yrs
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 Jan. '55, to Sept 15-60 and last saw her alive on Sept. 1-60
Death occurred at 5 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 Conrad M.D.
22b. ADDRESS Chillicothe Mo
22c. DATE SIGNED Sept. 16-60

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 9/17/1960
23c. NAME OF CEMETERY OR CREMATORY Parson Creek Cemetery
23d. LOCATION (City, town, or county) Wheelthy (State) Mo

24. FUNERAL DIRECTOR E.J. Robertson ADDRESS Funeral Home - Chula
25. DATE RECD. BY LOCAL REG. Sep. 16, 1960
26. REGISTRAR'S SIGNATURE Annalee Taylor

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed J M Robertson

Licensed Embalmer No. 4388

P. O. Address Laredo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com 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.