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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 8 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18176

Registration District No. 141 Primary Registration District No. 302d Registrar's No. 51

1. PLACE OF DEATH:

(a) County HOWELL
(b) City or town WEST PLAINS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 219 E. OLDEN ST. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution No. (Specify whether
In this community 44 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County HOWELL 46
(c) City or town WEST PLAINS,
(If outside city or town limits, write "RURAL")
(d) Street No. 219 E. OLDEN ST. 1
(If rural, give location)
(e) Citizen of foreign country? No. 1 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME BETTIE NEWTON

3. (b) If veteran, name war —
3. (c) Social Security No. —

4. Sex FEMALE 1
5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED 1
6. (b) Name of husband or wife JOHN L. NEWTON
6. (c) Age of husband or wife if alive 86 years
7. Birth date of deceased MARCH (Month) 9 (Day) 1862 (Year)

8. AGE: Years 82 Months 1 Days 21 If less than one day hr. min.

9. Birthplace MTN. GROVE, (City, town, or county) Mo. 6 (State or foreign country)
10. Usual occupation NONE
11. Industry or business
FATHER
12. Name WM. J. ARGNBRIGHT
13. Birthplace (City, town, or county) VA. 1 (State or foreign country)
MOTHER
14. Maiden name MARTHA LEE
15. Birthplace (City, town, or county) TENN. 1 (State or foreign country)
16. (a) Informant JOHN L. NEWTON
(b) Address WEST PLAINS, Mo.
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 2, 1944 (Month) (Day) (Year)
(c) Place: burial or cremation OAK LAWN CEM. WEST PLAINS, Mo.
18. (a) Signature of funeral director Hal Thornburgh
(b) Address WEST PLAINS, Mo.
19. (a) 5/10-44 (Date received local registrar) (b) Paul Harling (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 30, year 1944 hour 1: minute 15 A.M.

21. I hereby certify that I attended the deceased from March 20, 1944, to April 30, 1944 that I last saw her alive on April 23, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Arteriosclerosis

Due to

Other conditions (Include pregnancy within 3 months of death) 83a

Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)
Address West Plains, Mo. May 2 Date signed 4-4

1125

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 46351
Date Filed 6 7 44

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~~ .....

..... Registered Apprentice No. .....

working under my personal supervision.

Signed Hal Thoroughgood

Licensed Embalmer No. 3400

P. O. Address West Plains, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.