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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 17 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13754

Registration District No. 741

Primary Registration District No. 5550

Registrar's No. 6

1. PLACE OF DEATH:

(a) County: HOWELL

(b) City or town: MOODY Barton Twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: No (Specify whether years, months or days)

In this community: 60 YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State: MISSOURI (b) County: HOWELL 46

(c) City or town: MOODY 0
(If outside city or town limits, write "RURAL") 0

(d) Street No.:
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country:

3. (a) PRINT FULL NAME: NEWTON FRANCIS McCALLON

3. (b) If veteran, name war: —

3. (c) Social Security No.: —

4. Sex: MALE 0

5. Color or race: WHITE

6. (a) Single, widowed, married, divorced: WIDOWED

6. (b) Name of husband or wife: MARY L. McCALLON

6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: JANUARY (Month) 29 (Day) 1863 (Year)

8. AGE: Years 82 | Months 1 | Days 2 | If less than one day: hr. min.

9. Birthplace: MEIGS Co., (City, town, or county) TENN. 1 (State or foreign country)

10. Usual occupation: NONE

11. Industry or business:

FATHER
12. Name: UNKNOWN
13. Birthplace: UNKNOWN 9 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: UNKNOWN
15. Birthplace: UNKNOWN 9 (City, town, or county) (State or foreign country)

16. (a) Informant: C. C. McCALLON
(b) Address: WEST PLAINS, Mo.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: MAR. 4, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation: MOODY Mo

18. (a) Signature of funeral director: Neal Thornburgh
(b) Address: WEST PLAINS, Mo

19. (a) 3-10-45 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 1, year 1945 hour 10: minute 30 A. M.

21. I hereby certify that I attended the deceased from 2-27-1945 to 3-1 1945 that I last saw him alive on 2-27 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Ascending Paralysis — Duration

Due to: Not Known

Due to:

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy: 82:1

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: 0

23. Signature: L. E. Roe (M. D. ~~or other~~)

Address: Viola, Ark. Date signed 3-7-45

1121

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 445184
Date Filed 7.12.48

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 Thornburgh

Licensed Embalmer No. 3A08

P. O. Address West Plains, 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.