. S. No. 2
M—1-4-41
v. 5-17-39
I X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 22 1945

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30218

Registration District No. 43 — Primary Registration District No. 3007 — Registrar's No. 23a

1. PLACE OF DEATH:

(a) County Butler

(b) City or town Poplar Bluff, Mo.
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution about 6 hours (Specify whether
In this community 15 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Butler 12

(c) City or town Harviell Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? 1 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Leamon C. Newton

3. (b) If veteran, name war

3. (c) Social Security No. 493-28-1367

4. Sex m 0

5. Color or race white

6. (a) Single, widowed, married, divorced single 0

6. (b) Name of husband or wife mo

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

7. Birth date of deceased 8 (Month) 9 (Day) 1929 (Year)

8. AGE:	Years	Months	Days	If less than one day
16	16	6	25	hr. min.

9. Birthplace Bremen Ky. (City, town, or county) 1 (State or foreign country)

10. Usual occupation Stave Factory worker

11. Industry or business Factory

FATHER
12. Name Clifford Patterson Newton
13. Birthplace McHenry (City, town, or county) Ky. 1 (State or foreign country)

MOTHER
14. Maiden name Virdie Lee Vincent
15. Birthplace Bremen, (City, town, or county) Ky. 1 (State or foreign country)

16. (a) Informant Clifford P. Newton
(b) Address St. Louis, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8 (Month) 7 (Day) 1945 (Year)
(c) Place: burial or cremation Cockrum Cemetery

18. (a) Signature of funeral director Blacky Mortuary
(b) Address Cormy, Ark.

19. (a) 8-24-45 (Date received local registrar) R H Mendrec (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 4
year 45 hour 6 30 minute P M.

21. I hereby certify that I attended the deceased from Aug 4, 1945, to Aug 4, 1945
that I last saw him alive on Aug 4, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Streptococcus throat infection

Due to Streptococcus infection

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations no
Of autopsy no

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) no
(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) MD
Address [illegible] Date signed 8-22-45

1422 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 945-3024
Date Filed 9-17-45

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

William P. Beary, Registered Apprentice No. 99,
working under my personal supervision.

Signed Delan Johnson

Licensed Embalmer No. 686

P. O. Address Corning, Ark.

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.