

FILED FEB 13 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

8435

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3475 Registrar's No. 15

1. PLACE OF DEATH a. COUNTY <u>Stoddard</u> b. CITY (If outside corporate limits, write RURAL and give township) <u>Rural</u> c. LENGTH OF STAY (in this place) <u>WK</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Scott</u> c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural</u> OR TOWN <u>Richmond</u> d. STREET ADDRESS (If rural, give location) <u>Rt. 1 Sikeston, Missouri</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Rt 1 Sikeston Mo.</u>			d. STREET ADDRESS (If rural, give location) <u>1000</u>		

3. NAME OF DECEASED (Type or Print) a. (First) <u>Minnie</u> b. (Middle) <u>Belle</u> c. (Last) <u>Newton</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>January 20, 1953</u>		
--	--	--	--	--	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 2, 1881</u>	9. AGE (In years last birthday) <u>71</u>	10. IF UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 1 MIN. Hours _____ Mins. _____
----------------------	-------------------------------	---	--------------------------------------	---	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Caloway County, Kentucky</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
--	---	--	---

13a. FATHER'S NAME <u>Do not Know</u>	13b. MOTHER'S MAIDEN NAME <u>Do Not Know</u>	14. NAME OF HUSBAND OR WIFE <u>H. L. Newton, deceased</u>
---------------------------------------	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Clarence Ree Conran, Mo</u>	ADDRESS <u>Daughter</u>
---	-------------------------------------	---	-------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>6 hr.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Probably myocardial Infarct</u>		
	II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>Hypertensive heart disease</u>	
		DUE TO (c) _____	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
------------------------	----------------------------------	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I attended the deceased from 5 Sept, 1950, to 10 Sept, 1952, that I last saw the deceased alive on 10 Sept, 1952, and that death occurred at \_\_\_\_\_ m, from the causes and on the date stated above.

23a. SIGNATURE <u>H.S. Throgmorton</u> (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>Sikeston Mo.</u>	23c. DATE SIGNED <u>28 Jan 53</u>
--	----------------------------------	-----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Jan. 23, 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mound Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Highway 61-near Lilbour Mo</u>
---	--------------------------------	--	---

DATE REC'D BY LOCAL REG. <u>2-4-53</u>	REGISTRAR'S SIGNATURE <u>Mrs. Ella Hunter</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>H.S. Smith</u> ADDRESS <u>Funeral Home-Caruthers-</u>
--	---	---

W.L.C., Mo

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

RECEIVED FEB 9 1953  
SCOTT COUNTY HEALTH CENTER  
CO. FILE NO. 253-29

MAR 13 1953

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 .....  
Student Embalmer

Signed W. Denver Fike

Licensed Embalmer No. 4484

P. O. Address Courthensville, 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.