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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

FILED JUL 26 1945

STANDARD CERTIFICATE OF DEATH

State File No. 23941

Registration District No. 128

Primary Registration District No. 5466

Registrar's No.

1. PLACE OF DEATH:
(a) County GREENE
(b) City or town RURAL S. CAMPBELL TWP (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: OZARK OSTEOPATHIC HOSPITAL (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 135 days (Specify whether years, months or days)
In this community —

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Barry
(c) City or town Verona (If outside city or town limits, write "RURAL")
(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 Mr John Calton
3. (b) If veteran, name war —
3. (c) Social Security No. —

4. Sex Male
5. Color or race White
6. (a) ~~Single~~, widowed, ~~married~~, ~~divorced~~ W.
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive ... years
7. Birth date of deceased Oct (Month) 7 (Day) 1868 (Year)

8. AGE:

Years	Months	Days	If less than one day
77	7	12	— hr. — min.

9. Birthplace Berry County (City, town, or county) Mo. (State or foreign country)
10. Usual occupation
11. Industry or business

FATHER
12. Name Dave Colton
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Lona Danel
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Floyd Calton
(b) Address 726 So Lexington
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director Gallaway
(b) Address Monett Mo
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 21 year 1945 hour 4 am minute — AM.

21. I hereby certify that I attended the deceased from ..., 19..., to ..., 19...;
that I last saw h... alive on ..., 19...
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	PHYSICIAN Underline the cause to which death should be charged statistically.
Of autopsy	

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 R. A. Michael D.O. (M. D. or other)
Address Springfield Date signed

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

(Licensed Embalmer's Statement on Reverse Side)

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 J. D. Buchanan

Licensed Embalmer No. 3179

P. O. Address Monett 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.

No. 2B
1—3-45
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Aug

Registration District No. 128 Primary Registration District No. 5466 Registrar's No. 566

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

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Rural, S. Campbell Twp. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Ozark osteopathic Hosp. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Barry
(c) City or town Verona (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME John Calton
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Oct 7 1867 (Month) (Day) (Year)
8. AGE: Years 77 Months 7 Days 14 If less than one day hr. min.
9. Birthplace Unk. (City, town, or county) Mo (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name Dave Calton
13. Birthplace Berry Co (City, town, or county) Mo. (State or foreign country)
MOTHER 14. Maiden name Lona Dowell
15. Birthplace UNK (City, town, or county) Unk. (State or foreign country)
16. (a) Informant Mrs Floyd Calton
(b) Address Lexington Mo.
17. (a) (Burial, cremation, or removal) (b) Date thereof 7-23-45 (Month) (Day) (Year)
(c) Place: burial or cremation Calton Cem.
18. (a) Signature of funeral director Calloway
(b) Address Monett, Mo
19. (a) (Date received local registrar) (b) Dr W E Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 21, year 1945 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19 ;
that I last saw h alive on 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	PHYSICIAN — Underline the cause to which death should be charged statistically.
Of autopsy	

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 R. A. Mychael D.O. (M. D. or other)
Address Springfield Date signed

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