WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County: Madawy

Township: Independence

or Village: ~~Cowlitz~~

or City: ..... (NO. ..... St.: ..... Ward)

Registration District No. 626

Primary Registration District No. 5828

File No. 41998

Registered No. 12

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Amis R. Barton

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Single

DATE OF BIRTH: August (Month) 17 (Day), 1853 (Year)

AGE: 63 yrs. 2 mos. 11 ds. If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

BIRTHPLACE (City or town, State or foreign country): Vinton Co Ohio

PARENTS
NAME OF FATHER: Mason Barton
BIRTHPLACE OF FATHER (City or town, State or foreign country): Virginia
MAIDEN NAME OF MOTHER: Martha Robinet
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Athens Co. Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs T. H. Burns

(ADDRESS) Rosemond Mo

Filed Dec 10, 1916 Miriam Day. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Nov (Month) 8 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 3, 1916, to Nov 7, 1916, that I last saw him alive on Nov 7, 1916, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

1 Lobar Pneumonia 108

10 A (Duration) ..... yrs. ..... mos. 5 ds.

Contributory (SECONDARY): Cold

(Duration) ..... yrs. ..... mos. 5 ds.

8 (Signed) L. O. Nye M. D.

Nov 8, 1916 (Address) Powell

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 63 yrs. 2 mos. 11 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence: Kansas.

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cadbury	Nov. 9, 1916

UNDERTAKER	ADDRESS
Ray & Lotan	Powell Mo

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ..... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... (Month) ..... (Day), 1..... (Year)

AGE ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country) .....

PARENTS

NAME OF FATHER .....

BIRTHPLACE OF FATHER
(City or town, State or foreign country) .....

MAIDEN NAME OF MOTHER .....

BIRTHPLACE OF MOTHER
(City or town, State or foreign country) .....

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191..., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

..... (Month) ..... (Day), 191..... (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191...., to ....., 191...., that I last saw h..... alive on ....., 191.... and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (SECONDARY) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191.... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191....
UNDERTAKER	ADDRESS