

REC'D MAR 20 1939

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

7973
Do not use this space.

1. PLACE OF DEATH

(a) County Shelby Co Registration District No. 827
(b) Township Clary Primary Registration District No. 4500
(c) City Clarence Mo (d) Street No. _____ St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ St. ☐ (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF Miss Emma Smith (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2/3-1858
7. AGE 81 YEARS MONTHS 4 DAYS If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as saw mill, bank, etc. Farm
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Shelby Co Mo

FATHER 13. NAME Morgan Parker Barton

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky

MOTHER 15. MAIDEN NAME Elizabeth McProom

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia

17. INFORMANT (ADDRESS) James Barton
Moberly Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Bacon Chapel DATE 2/19 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Frank Hamilton
Clarence Mo

20. FILED 2/18 1939 Roy Hamilton
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 17 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
The principal cause of death and related causes of importance were as follows:

Cerebral Apoplexy

Other contributory causes of importance: 94

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

(Signed) Frank K. Roy M. D.
Clarence Mo
751 (Address)

RECEIVED

District Health Officer No. 10

District File Number 10-39-451

Date Filed MAR 14 1939

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 self

Registered Apprentice No. _____

working under my personal supervision.

Signed

Harold E. Whicision

Licensed Embalmer No.

3957

P. O. Address

Shelburne Vt

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

79 73

Do not use this space.

1. PLACE OF DEATH

(a) County Shelby Registration District No. 827
(b) Township _____ Primary Registration District No. 62-00 Registered No. 4
(c) City Clarence (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Stephen Lee Barton
(a) Residence, No. _____ St. ☐ (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
81 4

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME Morgan Parker Barton
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 2/18 W. H. Hamilton Local Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-17, 1918

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____

I last saw him alive on _____, 19____. Death is said

to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) Frank H. Ray, M. D.

(Address) Clarence

