

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42635**

FILED DEC 29 1945

Registration District No. **239**

Primary Registration District No. **4497**

Registrar's No. **79**

1. PLACE OF DEATH:

(a) County **SHELBY**
(b) City or town **CLARENCE**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **LIFE** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **EMMA S. BARTON**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **FEMALE** 5. Color or race **W**
6. (b) Name of husband or wife **FER BARTON** 6. (a) Single, widowed, married, divorced **WIDOW**
7. Birth date of deceased **6** 6. (c) Age of husband or wife if alive **DECEASED**
(Month) (Day) (Year)

8. AGE: Years **77** Months **4** Days **23** If less than one day hr. _____ min. _____

9. Birthplace **SHELBY MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSE KEEPER**

11. Industry or business _____

MOTHER FATHER { 12. Name **SIDNER SMITH**
13. Birthplace **KY**
(City, town, or county) (State or foreign country)
14. Maiden name **HUSTON**
15. Birthplace **KY**
(City, town, or county) (State or foreign country)

16. (a) Informant **NELSON BARTON**

(b) Address **CLARENCE**

17. (a) **BURIAL** (b) Date thereof **11/7-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **BACON CHAPPLE**

18. (a) Signature of funeral director **Million Barkelew**

(b) Address **Clarence mo**

19. **Dec 4-45** (b) **Ruth Jones**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **SHELBY**
(c) City or town **CLARENCE**
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **5th**
year **1945** hour **4** minute **30 AM**

21. I hereby certify that I attended the deceased from **1940**
_____, 19____, to **Nov 5-1945**
that I last saw her alive on **Nov 5-1945**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic myocarditis 5 yrs**
Duration _____

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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) _____
(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?

While at work? _____ (Specify type of place)
(2) Means of injury _____

23. Signature **D. L. Harlan** (M. D. or other) **Nov 30 1945**
Address **Clarence mo** Date signed _____

1547 (Licensed Embalmer's Statement on Reverse Side)

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

FEB 28 1951

RECEIVED

District Health Officer No. 10

District File Number 12-45-1906

Date Filed DEC 20 1945

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.....

Henry A. Barksdale

Licensed Embalmer No.

3835

P. O. Address.....

Shelburne 940

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.