

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-010045

FILED VS. MAR. 28 1960

042

Primary Registration District No.

Registrar's No.

362

STATE FILE NUMBER

INDEXED

|   |   |   |   |   |  |  |
|---|---|---|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Buchanan</b>  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo</b> b. COUNTY <b>Buchanan</b> |   |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Easton, Marion Twsp</b>   |   | Length of stay in 1b<br><b>47yrs</b>  | c. CITY OR TOWN <b>Easton</b>   |   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                 |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Rural Rt, Easton</b>  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  | d. STREET ADDRESS <b>Rural,</b>   |   | (If outside, give location)<br>Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Zula</b> Middle <b>May</b> Last <b>Barton</b>  |   |   | 4. DATE OF DEATH<br>Month <b>Mar.</b> Day <b>14,</b> Year <b>1960</b>   |   |  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Dec. 20, 1885</b>  | 9. AGE (last birthday)<br><b>74yrs</b>  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House wife</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  | 11. BIRTHPLACE (City and state or country)<br><b>Platte County Mo</b>   |   | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A</b>  |  |
| 13a. FATHER'S NAME<br><b>John W Roberts</b>   |   | 13b. MOTHER'S MAIDEN NAME<br><b>Emmaline Gibson</b>   |   | 14. NAME OF HUSBAND OR WIFE<br><b>Forrest Barton</b>  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |   | 16. SOCIAL SECURITY NO.<br><b>none</b>  | 17. INFORMANT<br>Address<br><b>Forrest Barton, Easton Mo</b>  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary occlusion</b>   |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b>  |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Coronary occlusion</b>  |   |   |   |   |  |  |
| DUE TO (c)  |   |   |   |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)   |   |   |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)  |   |   |  |  |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. p.m.   |   |   |   |   |  |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 20f. CITY, TOWN, OR LOCATION  | COUNTY  | STATE   |  |  |
| 21. I attended the deceased from <b>Apr 1949</b> to <b>3/14/60</b> and last saw her alive on <b>3-4-1960</b><br>Death occurred at <b>4:30 P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |   |   |  |  |
| 22a. SIGNATURE<br>(Degree or title)<br><b>Dr L. H. Fison M.D.</b>   |   | 22b. ADDRESS<br><b>St Joseph 720</b>  |   | 22c. DATE SIGNED<br><b>3-19-60</b>  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE<br><b>3/18/60</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Frazer Cemetery</b>  | 23d. LOCATION (City, town, or county)<br><b>Frazer Mo</b>   |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>John Rupp</b>  |   | ADDRESS<br><b>Joseph, Mo</b>  | 25. DATE RECD. BY LOCAL REG.<br><b>Mar. 24, 1960</b>  | 26. REGISTRAR'S SIGNATURE<br><b>Wm Clark Gardell</b>  |  |  |

DOCUMENT

L.H. Fison M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

