

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

21503

State File No. \_\_\_\_\_

66

Registrar's No. \_\_\_\_\_

Registration District No. D. J. 141

Primary Registration District No. 5551

1. PLACE OF DEATH:

(a) County Hovell  
(b) City or town Pear Valley P#1 Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Hovell Hosp  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 months (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Hovell  
(c) City or town Pear Valley P#1 Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? yes (Yes or No)  
If yes, name country. 1

3. (a) PRINT FULL NAME MARY E BARTON

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Wm Barton 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased April 24 1860  
(Month) (Day) (Year)

8. AGE: Years 83 Months 1 Days 24 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Town 1  
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name John Southurst  
13. Birthplace Pa 1  
(City, town, or county) (State or foreign country)  
14. Maiden name Esther Parker  
15. Birthplace Pa 1  
(City, town, or county) (State or foreign country)

16. (a) Informant Mattie Johnson

(b) Address Pear Valley Mo

17. (a) Removal June 18 1943  
(Burial, cremation, or removal) (Date thereof) (Month) (Day) (Year)

(c) Place: burial or cremation Catholyn Buffalo

18. (a) Signature of funeral director S. B. Mead

(b) Address 13 Buffalo Mo

19. (a) 25-43 (b) Paul Harris  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 18 year 43 hour 2 minute 30 A.M.

21. I hereby certify that I attended the deceased from June 10, 1943, to June 18, 1943, that I last saw her alive on June 16, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic Heart Disease  
Coronary Occlusion

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
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? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature Cele Bohrer (M. D. or other) MD  
Address West Plains Mo Date signed 6-19-43

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

4600

1125-

RECEIVED

District Health Officer No. 5,

District File Number 743401

Date Filed 7. 6 - 43

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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 Hal Thomburg

Licensed Embalmer No. 3408

P. O. Address West Plains

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.