

**FILED NOV 19 1946**

Registration District No. **209**

Primary Registration District No. **3043**

Registrar's No. **348**

1. PLACE OF DEATH:

(a) County **MARION**  
 (b) City or town **HANNIBAL**  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: **LEVERING HOSPITAL**  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **24 hours**  
(Specify whether years, months or days)  
 In this community **Life time**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Marion**  
 (c) City or town **Palmyra**  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME **James Ezra Barton**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **July 4th 1880**  
(Month) (Day) (Year)

8. AGE: Years **66** Months **3** Days **20** If less than one day  
 hr. \_\_\_\_\_ min.

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

10. Usual occupation **Farmer.**

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

12. Name **Daniel P. Barton**

13. Birthplace **Quincy Illinois**  
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Jane Brothers**

15. Birthplace **Illinois**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Mary Barton**

(b) Address **Palmyra Mo.**

17. (a) **Burial** (b) Date thereof **Oct. 26, 1946**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Greenwood Cem. Palmyra**

18. (c) Signature of funeral director **Ernest J. Sparger**

(b) Address **Palmyra Mo.**

19. (a) **Oct 28 46** (b) **E. M. Lucke**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **24**  
 year **1946** hour **12** minute **40 A.M.**

21. I hereby certify that I attended the deceased from **Oct 22** to **Oct 25**, 19**46**  
 that I last saw him alive on **Oct 24**, 19**46**  
 and that death occurred on the date and hour stated above.

Immediate cause of death **Starvation**  
 Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**  
 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? **No.**

(e) While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature **J. H. Hill, M.D.** (M. D. or other) \_\_\_\_\_

Address **Palmyra Mo.** Date signed **10/26/46**

MOTHER FATHER

**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..... *Ernest J. Spurgeon*.....

Licensed Embalmer No..... 3245.....

P. O. Address..... Palmyra Mo. ....

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

**If this body is not embalmed, fact should be so stated above.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. See  
Registrar's No. 348

Registration District No. 209 Primary Registration District No. 3043

1. PLACE OF DEATH:  
(a) County Marion  
(b) City or town Harrisburg  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days  
3. (a) PRINT FULL NAME James E. Barten  
3. (b) If veteran name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased July (Month) 4 (Day) 1946 (Year)

8. AGE: Years 66 Months 3 Days 20 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_  
9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_  
17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_  
19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_ Year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death stroke  
Duration \_\_\_\_\_  
Due to Malnutrition  
Due to Senile dementia  
Other conditions: \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy 162B

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? \_\_\_\_\_  
(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_  
23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

MOTHER FATHER

2652

37703