

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

5239-62-038568  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_

**FILED OCT 25 1962**

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

Philip D. Reist, M.D. MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>KANSAS CITY</b>		Length of stay in 1b <b>20 YEARS</b>	c. CITY OR TOWN <b>KANSAS CITY</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF DECEASED (If not in hospital, give location) <b>3522 WALNUT STREET WALNUT NURSING HOME</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>416 EAST 36TH STREET</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle _____ Last <b>BARTON</b>			4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>14</b> Year <b>1962</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11/30/74</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	9. AGE (last birthday) <b>87</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) <b>PERU, ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>JACOB B. LITCOH</b>		13b. MOTHER'S MAIDEN NAME <b>ANNA BLITCH</b>	
14. NAME OF HUSBAND OR WIFE <b>GEORGE BARTON</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Arteriosclerosis heart disease venous</b>			INTERVAL BETWEEN ONSET AND DEATH <b>several hrs</b> <b>2 mos</b>
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 Hour _____ a.m. _____ p.m.	Month, Day, Year _____		
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>11-1-61</b> to <b>Oct 14, 62</b> and last saw her alive on <b>Sept 30, 62</b> . Death occurred at <b>3:40 P.</b> m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Philip D. Reist, M.D.</i>		22b. ADDRESS <b>518 Argyle Bldg</b>	
22c. DATE SIGNED <b>10/15/62</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>	23b. DATE <b>OCT. 17, '62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>D. W. NEWCOMER'S SONS</b>	23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>
24. FUNERAL DIRECTOR <b>D. W. NEWCOMER'S SONS</b>		25. DATE RECD. BY LOCAL REG. <b>10-16-62</b>	26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>
ADDRESS <b>1331 BRUSH CR</b>			
<b>KANSAS CITY, MO.</b>			

USE BLACK INK  
OR  
TYPEWRITER RIBBON

Dr. Phillips D. Parson  
Chicago, Ill.

**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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Dean W. Huff

Licensed Embalmer No. 4914

P. O. Address Indy, Mo.

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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