FILED MAR 3 01971

DEPARTMENT OF PUBLIC HEALTH AND WELFARE — MISSOURI DIVISION OF HEALTH

(PHYSICIAN OR CORONER)

CERTIFICATE OF DEATH

124

STATE FILE NUMBER 71 0011788

DO NOT WRITE ON THIS STUB

VS 300 Rev. 1/70

Registration District No. 316 Primary Registration District No. 3060 Registrar's No. 139

9.	1
10a.	84
10b.	
11.	0
12.	2
13.	4339
14.	
15.	4
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18.	0
19.	CREDITS
20.	1-0

4. 0945
5. 03

DECEASED

1. DECEASED—NAME (FIRST, MIDDLE, LAST): Ida B. Barton
2. SEX: Female
3. DATE OF DEATH (MONTH, DAY, YEAR): March 26, 1971
4. RACE (WHITE, NEGRO, AMERICAN INDIAN, ETC.) (SPECIFY): White
5a. AGE—LAST BIRTHDAY (YEARS): 84
5b. UNDER 1 YEAR — MOS.: 7 DAYS: 14
5c. UNDER 1 DAY — HOURS: MIN.:
6. DATE OF BIRTH (MONTH, DAY, YEAR): Aug. 12, 1886
7a. COUNTY OF DEATH: St. Francois
7b. CITY, TOWN, OR LOCATION OF DEATH: Farmington
7c. INSIDE CITY LIMITS (SPECIFY YES OR NO): yes
7d. HOSPITAL OR OTHER INSTITUTION—NAME (IF NOT IN EITHER, GIVE STREET AND NUMBER): Community Hosp.
8. STATE OF BIRTH (IF NOT IN U.S.A., NAME COUNTRY): Missouri
9. CITIZEN OF WHAT COUNTRY: U.S.A.
10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (SPECIFY): Widowed
11. SURVIVING SPOUSE (IF WIFE, GIVE MAIDEN NAME):
12. SOCIAL SECURITY NUMBER:
13a. USUAL OCCUPATION (GIVE KIND OF WORK DONE DURING MOST OF WORKING LIFE, EVEN IF RETIRED): Housewife
13b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE WHERE DECEASED LIVED. IF DEATH OCCURRED IN INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION.

6. 0946

14a. RESIDENCE—STATE: Missouri
14b. COUNTY: St. Francois
14c. CITY, TOWN, OR LOCATION: Desloge
14d. INSIDE CITY LIMITS (SPECIFY YES OR NO): yes
14e. STREET AND NUMBER: 203 S. Cowling

PARENTS

15. FATHER—NAME (FIRST, MIDDLE, LAST): Alexander Williams
16. MOTHER—MAIDEN NAME (FIRST, MIDDLE, LAST): Mary Deloney

17a. INFORMANT—NAME: Mrs. William Lunsford
17b. MAILING ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP): 1411 E. Chestnut Desloge, Mo

CAUSE

PART I. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c))

18. IMMEDIATE CAUSE (a): Cerebral Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 mo
DUE TO, OR AS A CONSEQUENCE OF:

CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST

(b): Cerebral arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF:

(c): Senility

PART II. OTHER SIGNIFICANT CONDITIONS: CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (a): A.S.H.D.

19a. AUTOPSY (YES OR NO): no
19b. IF YES WERE FINDINGS CONSIDERED IN DETERMINING CAUSE OF DEATH:

20a. ACCIDENT, SUICIDE, HOMICIDE, OR UNDETERMINED (SPECIFY):
20b. DATE OF INJURY (MONTH, DAY, YEAR):
20c. HOUR:
20d. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART II, ITEM 18):
20e. INJURY AT WORK (SPECIFY YES OR NO):
20f. PLACE OF INJURY AT HOME, FARM, STREET, FACTORY, OFFICE BLDG., ETC. (SPECIFY):
20g. LOCATION (STREET OR R.F.D. NO., CITY OR TOWN, STATE):
20h. IF DECEASED WAS FEMALE WAS THERE A PREGNANCY IN LAST 90 DAYS? ☐ YES ☐ NO ☐ UNK

CERTIFIER

21a. CERTIFICATION—PHYSICIAN: I ATTENDED THE DECEASED FROM 3/21/71
21b. TO 3-26-71
21c. AND LAST SAW HIM/HER ALIVE ON 3/25/71
21d. I DID/DID NOT VIEW THE BODY AFTER DEATH: Did
21e. DEATH OCCURRED AT THE PLACE, ON THE DATE, AND, TO THE BEST OF MY KNOWLEDGE, DUE TO THE CAUSE(S) STATED. (HOUR): 7:15 A.M.

22a. CERTIFICATION—MEDICAL EXAMINER OR CORONER: ON THE BASIS OF THE EXAMINATION OF THE BODY AND/OR THE INVESTIGATION, IN MY OPINION, DEATH OCCURRED ON THE DATE AND DUE TO THE CAUSE(S) STATED. HOUR OF DEATH: M.
22b. THE DECEDENT WAS PRONOUNCED DEAD — MONTH, DAY, YEAR, HOUR: M.

23a. CERTIFIER—NAME (TYPE OR PRINT): R. A. Huckstep M.D.
23b. SIGNATURE: R. A. Huckstep M.D.
23c. DEGREE OR TITLE:
23c. DATE SIGNED (MONTH, DAY, YEAR): 3/27/71
23d. MAILING ADDRESS—CERTIFIER (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP): Medical Arts Bldg. Farmington, Mo 63640

BURIAL

24a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
24b. CEMETERY OR CREMATORY—NAME: Parkview Cemetery
24c. LOCATION (CITY OR TOWN, STATE): Farmington, Missouri
24d. DATE (MONTH, DAY, YEAR): March 28, 1971
25a. FUNERAL HOME—NAME AND ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP): Murphy L. Sparks F. Home, Inc. Flat River, Mo 63601
26a. FUNERAL DIRECTOR—SIGNATURE: Murphy L. Sparks
REGISTRAR—SIGNATURE: Esther Williams
26b. DATE RECEIVED BY LOCAL REGISTRAR: March 29, 1971

Type or print in PERMANENT BLACK INK. See handbook for instructions.

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 Murphy L Sparks

Licensed Embalmer No. 4556

P. O. Address Flat River 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.