

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Madison

Township \_\_\_\_\_

or \_\_\_\_\_

Village \_\_\_\_\_

or \_\_\_\_\_

City Marquette (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 625

File No. 14120

Primary Registration District No. 3031

Registered No. 28

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

John J. Bartram

PERSONAL AND STATISTICAL PARTICULARS

3 SEX  Male  Female  
4 COLOR OR RACE White  
5 SINGLE  MARRIED  WIDOWED  OR DIVORCED   
(Write the word)

6 DATE OF BIRTH July 5 1848  
(Month) (Day) (Year)

7 AGE 69 yrs. 7 mos. 5 ds.  
IF LESS than 1 day, hrs. or min.?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Traveling Salesman  
(b) General nature of industry, business, or establishment in which employed (or employer) Lighting Rod Factory

9 BIRTHPLACE  
(City or town, State or foreign country) Monroe Co Ohio

10 NAME OF FATHER Milo Bartram

11 BIRTHPLACE OF FATHER  
(City or town, State or foreign country) Michigan

12 MAIDEN NAME OF MOTHER \_\_\_\_\_

13 BIRTHPLACE OF MOTHER  
(City or town, State or foreign country) \_\_\_\_\_

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Irwin Bartram

(Address) Marquette Mo

15 Filed 4-11 1918

J. M. Dutton  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 10 1918  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from April 3 1918 to April 8 1918  
that I last saw him alive on April 8 1918  
and that death occurred, on the date stated above, at 10 A. M.

The CAUSE OF DEATH\* was as follows:

Coronary Thrombosis

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY Mitral Stenosis  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) K. C. Cummings M. D.  
April 10 1918 (Address) Marquette Mo

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Graham Mo

DATE OF BURIAL 4-12 1918

20 UNDERTAKER J. B. Cummings

ADDRESS Marquette Mo

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
Association.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "*Asthenia*," "*Anaemia*" (merely symptomatic), "*Atrophy*," "*Collapse*," "*Coma*," "*Convulsions*," "*Debility*" ("*Congenital*," "*Senile*," etc.), "*Dropsy*," "*Exhaustion*," "*Heart failure*," "*Haemorrhage*," "*Inanition*," "*Marasmus*," "*Old age*," "*Shock*," "*Uraemia*," "*Weakness*," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*PUERPERAL septicaemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

6/11/19

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BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County nodaway

Township.....  
or  
Village.....

City Marysville (NO..... St..... Ward.....)

Registration District No. 625

File No.....

Primary Registration District No. 3031

Registered No. 28

2 FULL NAME

John J. Bartman

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH..... 1..... 191.....  
(Month) (Day) (Year)

7 AGE..... yrs..... mos..... ds. If LESS than 1 day..... hrs. or..... min.?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work.....  
(b) General nature of industry, business, or establishment in which employed (or employer).....

9 BIRTHPLACE  
(City or town, State or foreign country).....

PARENTS  
10 NAME OF FATHER.....  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country).....  
12 MAIDEN NAME OF MOTHER Unknown  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant).....  
(Address).....

15 Filed 4-11 1918 J. P. Cuttrey Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr - 10 8  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from..... to....., 191....., that I last saw h..... alive on....., 191....., and that death occurred, on the date stated above, at.....m. The CAUSE OF DEATH\* was as follows:

(Duration)..... mos..... ds.

CONTRIBUTORY (Secondary)..... (Duration)..... yrs..... mos..... ds. (Signed)..... M. D. (Address)....., 191.....

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) Other Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (Ex. Hospitals, Institutions, Transients, or Recent Residents) At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted if not at place of death?..... Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL..... DATE OF BURIAL....., 191.....

20 UNDERTAKER..... ADDRESS.....

Satisfactory Information Supplied

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