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

Do not use this space.

37386

File No. .....

Registered No. 39

JAN 1 9 1928

PLACE OF DEATH

County Lafayette

Township Freedom

City ..... (No. ....., ..... St. ..... Ward)

Registration District No. 457

Primary Registration District No. 5621 B

2. FULL NAME Martin Bartels

(a) Residence. No. ..... St., ..... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) |
|---|---|---|
| Male | White | Married |

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Martha Bartels

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 14th 1865

| 7. AGE Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|
| 62 | 5 | 18 | |

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Concordia, Mo.
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Henry Bartels

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Dora Scheringhaus

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany

14. INFORMANT Emil Bartels
(Address) Aullville, Mo.

15. FILED Dec 6, 1927 Ferdinand Shryman
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 2, 1927

17. I HEREBY CERTIFY, That I attended deceased from Dec. 2, 1927, to Dec 2, 1927 that I last saw h. alive on Dec. 2, 1927, and that death occurred, on the date stated above, at 11:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis

13 C 11 6

11 5 B 11 6 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Focal Infection of teeth, (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

0 DID AN OPERATION PRECEDE DEATH? No. DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J. L. Allen D.O. ~~M.D.~~

12-3, 1927. (Address) Higginsville, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

| 19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL |
|---|---|
| Cecy | 12/3/27 |

20. UNDERTAKER A. E. Harlan

ADDRESS Higginsville, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

THIS CERTIFICATE, WHEN COMPLETED, BECOMES A PERMANENT RECORD