

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

MAY 28 1929

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

Do not use this space.

15475

1. PLACE OF DEATH

County Newton Registration District No. 611
Township Five Mile Primary Registration District No. 6268
City (No. _____) _____ St. _____ Ward _____

File No. _____
Registered No. _____

2. FULL NAME

John Baptist Cartright

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (or use the word) Widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 14 1843

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
85 3 11

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) New Jersey
(STATE OR COUNTRY)

10. NAME OF FATHER Martin Cartright

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

12. MAIDEN NAME OF MOTHER No Record

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) No Record

14. INFORMANT Verl Cartright
(Address) RFD # 3

15. FILED 5/1 1929 C. E. Morris
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 25 1929

17. I HEREBY CERTIFY That I attended deceased from March 7, 1929, to April 22, 1929.
that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at 10:55 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Coronary
Bleeding disease
(duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY (SECONDARY) Redump
(duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS _____
(Signed) G. N. Jones, M. D.
5/2, 1929 (Address) Galena Kansas

*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 Hill Crest Cem DATE OF BURIAL Apr 28 1929

20. UNDERTAKER Kortner Clark ADDRESS Galena Kansas

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.

1
2
2
31

Bones

