V: 9888

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

Do not use this space. 24526

309

1002

1. PLACE OF DEATH

County Jackson — Registration District No. ..... — File No. .....

Township Kans — Primary Registration District No. ..... — Registered No. .....

City Kansas City (No. 3215 East 28th St. ..... St. ..... Ward)

2. FULL NAME Lester A Bartlett

(a) Residence. No. 3215 East 28th St., 11 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 30 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)
M	wh	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 21st 1849

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
80	1	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) K. C. Pub Service Co
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Ill

PARENTS

10. NAME OF FATHER Moses Bartlett

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

12. MAIDEN NAME OF MOTHER Martha Harper

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

14. INFORMANT Wm G. Bartlett
(Address) 3219 Woodland ave

15. FILED 7/5, 1929 M. M. Crowe asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/3/29 19

17. I HEREBY CERTIFY, That I attended deceased from Mch 1st, 1929, to July 3rd, 1929 that I last saw him alive on July 3rd, 1929, and that death occurred, on the date stated above, at 3 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Euremic Poisning
131
132 B

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Nephritis, Chronic

..... (duration) ..... yrs. ..... mos. ..... ds.

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? observation

(Signed) W H Caffey, M. D.
7/5, 1929 (Address) 606 Shukert Bldg.

*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
Mt Moriah Cem	7/6/29 19

20. UNDERTAKER	ADDRESS
W. F. Mayberry Co	City 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.

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

606 [illegible]

[illegible] 9888

[illegible]