LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

16030

JUL 20 1935

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

V. S. No. 2.

MARGIN RESERVED

WRITE PLAINLY, WITH UNFADING INK—THIS

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

PLACE OF DEATH
County: Douglas Registration District No.: 281 File No.:
Township: Washington Primary Registration District No.: 5400 Registered No.:
City: (No. ; St. Ward)

FULL NAME: Reuben Hartly

(a) Residence. No. near Ava Mo 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

SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF ~~(OR) WIFE OF~~: Margaret Hartley

DATE OF BIRTH (MONTH, DAY AND YEAR): 9-27-1846

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89	8		

OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

BIRTHPLACE (CITY OR TOWN): near Ava
(STATE OR COUNTRY): Mo.

10. NAME OF FATHER: Andrew Hartly

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

12. MAIDEN NAME OF MOTHER:

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

INFORMANT: Lee Hartley (son)
(Address): Ava Mo

FILED: 7-18, 1935 G. D. Hale, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 5-27-1935

17. I HEREBY CERTIFY, That I attended deceased from 5-1-, 1935, to 6-26, 1935, that I last saw alive on 6-26, 1935, and that death occurred, on the date stated above, at 4:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arterial schlerosis
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Mitral stenosis
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED?
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. L. Gentry, M. D.
, 19 (Address) Ava 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Ava Mo.
DATE OF BURIAL: 5-28, 1935

20. UNDERTAKER: C. W. Blankinship
ADDRESS: Ava Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

NG A PERMANENT RECORD

stated EXACTLY. PHYSICIANS should state statement of OCCUPATION is very important.

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No.....,..... St. ..... Wa

2. FULL NAME .....

(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

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

DATE OF BIRTH (MONTH, DAY AND YEAR)

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

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

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

NAME OF FATHER

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

MAIDEN NAME OF MOTHER

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

INFORMANT .....
(Address)

FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19
that I last saw h..... alive on....., 19....., a
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

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

CONTRIBUTORY.....
(SECONDARY)

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

18. WHERE WAS DISEASE CONTRACTED

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

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....

, 19 (Address)

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIA
20. UNDERTAKER	ADDRESS