

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

Do not use this space.

FEB 21 1939

1. PLACE OF DEATH

County Cass
Township Polk
City Strasburg (No. 634)

Registration District No. 1569
Primary Registration District No. 5224

File No. 1946
Registered No. 1
St. _____ Ward _____

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. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 30 - 1876

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
62 9 15

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housekeeper

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Crawford County, Missouri
(STATE OR COUNTRY)

13. NAME S. G. Bartlett

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

15. MAIDEN NAME Mary Jane Harrison

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

17. INFORMANT Mrs. H. C. Hayston
(ADDRESS) Pleasant Hill, Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Strasburg, Mo. DATE 1-16-39

19. UNDERTAKER D. D. Nofsinger
(ADDRESS) Pleasant Hill, Mo.

20. FILED 1-20-1939 W. Beckman
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 15 1939

22. I HEREBY CERTIFY, That I attended deceased from 1-9, 1939, to 1-15, 1939

I last saw her alive on 1-14, 1939. Death is said to have occurred on the date stated above, at 5 A. m.

The principal cause of death and related causes of importance were as follows:

Paralysis ✓

Date of onset

1/9/39

Other contributory causes of importance:
Chronic Valvular Heart Disease

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
If so, specify _____

(Signed) W. Beckman, M. D.

(Address) Strasburg, 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.

WHITE PAPER, WITH UNWRAPPING MARK—THIS IS A PERMANENT RECORD

I 39314

92a

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

1946
Do not use this space.

1. PLACE OF DEATH

(a) County Cass Registration District No. 15-9
(b) Township Park Primary Registration District No. 3224 Registered No. _____
(c) City _____ (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S. if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Anna May Bartlett

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S (write the word)

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
62 9 15-

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

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

FATHER
13. NAME

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

MOTHER
15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 20 1939 W. Beckman Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-15, 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____

I last saw h. alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

paternal Cerebral Hemorrhage
Chronic Valvular Disease
Date of onset

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) W. B. Beckman, M. D.
(Address) Strasburg Mo.

NCB—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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENT

S-1946