

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **29737**

REG. SEP 21 1939 578
Registration District No. **578**

Primary Registration District No. **4340**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **MONROE**
(b) City or town **HOLLIDAY**
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether _____)

In this community _____ years, months or days

3. (a) PRINT FULL NAME **GOLDIE B. HARTMAN**

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **FRED HARTMAN** 6. (c) Age of husband or wife if alive **44** years

7. Birth date of deceased **JUNE 13 1900**
(Month) (Day) (Year)

8. AGE: Years **39** Months **2** Days **20** If less than one day _____ hr. _____ min.

9. Birthplace **SHELBY Co. Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **AT HOME**

11. Industry or business _____

MOTHER FATHER { 12. Name **CLARK GSIFFEN**

13. Birthplace **IND.**

14. Maiden name **NELLIE MONTGOMERY**

15. Birthplace **SHELBY Co. Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Fred Hartman**

(b) Address **HOLLIDAY, MO.**

17. (a) **BURIAL** (b) Date thereof **9-5-1939**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **BEINA Cem. HOLLIDAY, MO.**

18. (a) Signature of funeral director **Clayton Blakey**

(b) Address **PARIS, MO.**

19. (a) **9-4-39** (b) **Mrs. David G. Thompson**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **MONROE**

(c) City or town **RURAL**
(If outside city or town limits, write "RURAL")

(d) Street No. **1/4 MI. N. OF HOLLIDAY, MO**
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **SEPT.** day **3rd**
year **1939** hour **9** minute **20 P.** M.

21. I hereby certify that I attended the deceased from **April**, 1939, to **Sept 3rd**, 1939;
that I last saw her alive on **Sept 3**, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death **Myasthenia Gravis** Duration **20 yrs.**

Due to _____
Due to **156 lb**

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **F. A. Barnett** (M. D. or other) **MO**

Address **Paris, Mo** Date signed **9-4-39**

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.

RECEIVED

District Health Officer No. 10

District File Number ⁶ 9-29-1648

Date Filed -- SEP 14 1939

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed E. H. Agnew

Licensed Embalmer No. 4000

P. O. Address Paris, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.