

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.

DEC 15 1939

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

39793
Do not use this space.

1. PLACE OF DEATH

(a) County Howard

Registration District No. 878

(b) Township
or Fayette

Primary Registration District No. 422

Registered No. 72

(c) City

(d) Street No.

(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. da.

(f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No.

St.

(Usual place of abode, if no street address, write county or city)

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR
DIVORCED (write the word)

Widowed

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

Elizabeth Lay Bartee,

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

9/8th 1859

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day,hrs.
ormin.

80

2

16

OCCUPATION

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

Farmer.

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)

Missouri,

FATHER

13. NAME Joseph Bartee,

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

Missouri,

MOTHER

15. MAIDEN NAME Nancy Collier,

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

Missouri.

17. INFORMANT Elizabeth Green,
(ADDRESS) Fayette, Mo.

18. BURIAL, CREMATION, OR REMOVAL

PLACE Sharon Church. DATE 11/26th 1939

19. FUNERAL DIRECTOR (NAME) Guy T. Halley.

(ADDRESS) Fayette, Mo.

20. FILED Dec 5 1939 V. O. Bonham
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11. 24th 1939

22. I HEREBY CERTIFY, That I attended deceased from

11-23 1939, to 11-24 1939

I last saw him alive on 11-24 1939. Death is said

to have occurred on the date stated above, at 12:45 m.

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

Chronic Myocarditis
93C

Other contributory causes of importance:
Acute cardiac failure 11-24-39

Name of operation None Date of 1/0
What test confirmed diagnosis? Blood findings Was there an autopsy? 1/0

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? No
If so, specify M. J. Shaw, M. D.
(Signed) (Address) Fayette, Mo.

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 6/27/39

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.....

Licensed Embalmer No.....

P. O. Address.....

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.