

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11065
Registrar's No. 25

Registration District No. 334 Primary Registration District No. 4197

1. PLACE OF DEATH:
(a) County HARRISON
(b) City or town BETHANY, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
BETHANY HOSPITAL
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution 4 days (Specify whether years, months or days)

8. (a) PRINT FULL NAME JAMES BARTLETT
8. (b) If veteran, name war 1 8. (c) Social Security No. 34

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 9 4 1862
(Month) (Day) (Year)

8. AGE: Years 77 Months 6 Days 12 If less than one day hr. min.

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

10. Usual occupation RETIRED FARMER

11. Industry or business _____
12. Name JOSEPH BARTLETT
13. Birthplace WHITE Co., TENN.
(City, town, or county) (State or foreign country)
14. Maiden name CATHERINE BUCK
15. Birthplace WHITE Co., TENN.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature July Bartlett
(b) Address Bethany, Mo.

17. (a) BURIAL (b) Date thereof 3/18/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MIRIAM
18. (a) Signature of funeral director L. M. Haas
(b) Address Bethany, Mo.

19. (a) 3-21-40 (b) A. J. Weisberg
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County HARRISON
(c) City or town BETHANY
(If outside city or town limits, write "RURAL") 0
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 16
year 1940 hour 10:00AM minute _____ M.
21. I hereby certify that I attended the deceased from Mar. 12, 1940 to Mar. 16, 1940;
that I last saw him alive on Mar. 16, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic interstitial nephritis Duration 1935
Due to Engorgement - 2/20/40

Due to _____
Other conditions (include pregnancy within 8 months of death) _____

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically

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)
(a) Means of injury _____
23. Signature W. J. Bray (M. D. or other) MD
Address Bethany, Mo. Date signed 3/19/40

RECEIVED
District Health Officer No. 11,
District File Number 440-528
Date Filed APR 12 1940

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 Melvin Hasis

Licensed Embalmer No. 3899

P. O. Address Biltham, 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.