

NOV 21 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

36128

State File No.

Registration District No. 735

Primary Registration District No. 3034

Registrar's No. 208

1. PLACE OF DEATH:

(a) County Randolph
 (b) City or town Moberly
 (c) Name of hospital or institution: Mc Cormick Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community _____
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph
 (c) City or town Moberly
 (If outside city or town limits, write "RURAL")
 (d) Street No. 412 Farrar
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Rose M. Bartle

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Ernest Bartle 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 5th 1885
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
55 4 0 hr. min.

9. Birthplace neb
 (City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business _____

12. Name Fred Gile

18. Birthplace Germany
 (City, town, or county) (State or foreign country)

14. Maiden name Katherine Schmidt

16. Birthplace Luxemburg
 (City, town, or county) (State or foreign country)

16. (a) Informant Miss Evelyn Bartle

(b) Address Moberly Mo

17. (a) Burial (b) Date thereof Oct 7th 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Moberly Mo

18. (a) Signature of funeral director Mohran and Son

(b) Address Moberly

19. (a) Oct 7-1940 (b) Seab Willhade
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 5th year 1940 hour 6 minute Pr.

21. I hereby certify that I attended the deceased from Oct 1st to Oct 5th

that I last saw her alive on Oct 5th and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes Mellitus

Duration _____

Due to _____

Due to _____

Other conditions Duty to Foot
 (Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: _____

Of operations none

Of autopsy none

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? On Road at Moberly Mo
 (City or town) (County) (State)

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

9:25 (Specify type of place)

While at work? no (e) Means of injury fall

23. Signature O O Posh (M. D. or other) _____

Address Moberly Mo Date signed 10/7/40

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

1940
94

FEB 26 1945

RECEIVED

District Health Officer No. 10

District File Number 11-40-2160

Date Filed NOV 14 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 Frank S. D. Witt

Licensed Embalmer No. 3021

P. O. Address Moberly

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 36128

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 735

Primary Registration District No. 3034

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Randolph

(b) City or town Moberly
(If outside city or town limits, write "RURAL" and name of township)

(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Rose M. Bartle

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>55</u>	<u>4</u>	<u>0</u>	hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) _____ (Day) _____ (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

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

(d) Street No. _____ (If rural, give location)

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

20. DATE OF DEATH: Month Oct day 2
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h. _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes mellitus Duration _____

Due to _____

Due to _____ 195
40

Other conditions Injury of foot
(Include pregnancy within 9 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) Accident

(b) Date of occurrence Oct 2nd 1940

(c) Where did injury occur? on St of Moberly Mo
(City or town) _____ (County) _____ (State) _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? no

While at work? no (Specify type of place) _____
(e) Means of injury Struck nail in foot

23. Signature O. O. Ash (M. D. or other) _____

Address 220 1/2 W. Blvd Moberly Mo Date signed 10/18/40

SUPPLEMENTAL

