U. S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

JAN 22 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 43987

Registration District No. 796 | Primary Registration District No. 3038 | Registrar's No. 189

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

1. PLACE OF DEATH

(a) County: Saline
(b) City or town: Marshall (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Bryman Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 15 days (Specify whether years, months or days)
In this community: /

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Saline
(c) City or town: Forest Springs (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.

3. (a) PRINT FULL NAME: LULA BELLE HARTMAN
3. (b) If veteran, name war: ✓
3. (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: Walter Hartman
6. (c) Age of husband or wife if alive: 50 years
7. Birth date of deceased: Mar (Month) 7 (Day) 1895 (Year)

8. AGE: Years	Months	Days	If less than one day
44	9	22	hr. min.

9. Birthplace: Saline Co (City, town, or county) Mo (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business: at home
MOTHER FATHER
12. Name: Albert Jenkins
13. Birthplace: (City, town, or county) (State or foreign country)
14. Maiden name: Beckie Ellen Hunt
15. Birthplace: Cooper Co (City, town, or county) Mo (State or foreign country)
16. (a) Informant: Walter Hartman
(b) Address: Forest Spring Mo
17. (a) Buried (Burial, cremation, or removal) (b) Date thereof 12/31/40 (Month) (Day) (Year)
(c) Place: burial or cremation: Bignell Cemetery
18. (a) Signature of funeral director: R C Carter
(b) Address: Forest Spring Mo
19. (a) 12-30-40 (Date received by local registrar) (b) Mary Kent Deputy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC day 29 1940 year 1940 hour 11 minute 15 A. M.
21. I hereby certify that I attended the deceased from Dec. 14, 1940 to Dec. 29, 1940 that I last saw her alive on Dec. 29, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchial pneumonia — Duration: 10 days
Due to: Vaginal hysterectomy
Due to: On Dec. 14, 1940
Other conditions (Include pregnancy within 3 months of death): Anuria
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? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: [illegible] M.D. (M. D. or other)
Address: Marshall, Mo Date signed 12-30-40

(Licensed Embalmer's Statement on Reverse Side)

1072

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 1-10-41

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 R C Carter

Licensed Embalmer No. 3513

P. O. Address [illegible]

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.

S. No. 2B
1—2-21-40
I X22659

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

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BUREAU OF THE CENSUS

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STANDARD CERTIFICATE OF DEATH

State File No. 43987

Registration District No. 796 Primary Registration District No. 3038 Registrar's No. 189

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Marshall (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 years, months or days) In this community

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.

3. (a) PRINT FULL NAME Lula Belle Hartman

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 M

6. (b) Name of husband or wife

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

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

8. AGE: Years 44 Months 9 Days 22 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER 12. Name

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

MOTHER 14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 29 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 Bronchial Pneumonia

Due to Vaginal Hysterectomy on Dec 14 1940

Due to Prolapsus of fibroid uterus

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

Major findings:
Of operations

Of autopsy

54 B

Duration 12-4 1940

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. ~~or other~~)

Address Marshall, Mo Date signed 2-20-4