

Registration District No. **FILED MAY 25 1948**

Primary Registration District No. **6220**

Registrar's No.

1. PLACE OF DEATH:

(a) County **Vernon**
(b) City or town **Arcadia, Kans. R.F. 6**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **71 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Vernon 108**
(c) City or town **Arcadia, Kans. R.F. 6**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Lewis J. Hartzfeld**

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

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **etia** 6. (c) Age of husband or wife if alive **67** years

7. Birth date of deceased **Aug 29**
(Month) (Day) (Year)

8. AGE: Years **77** Months **6** Days **15** If less than one day hr. min.

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

10. Usual occupation **Retired Farmer**

11. Industry or business _____

12. Name **Godfrey Hartzfeld**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Wilson Hartzfeld**

(b) Address **mine aka**

17. (a) **Burial** (b) Date thereof **3 19 46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Wassley cemetery**

18. (a) Signature of funeral director **H.T. Noonan**

(b) Address **Arcadia, Kans**

19. (a) **4-6-1946** (b) **Ruth Fauth**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **16**
year **1946** hour **4:30** minute _____ PM.

21. I hereby certify that I attended the deceased from **on**
Mar. 13 19**46** to **Mar. 13** 19**46**
that I last saw him alive on **Mar. 13** 19**46**
and that death occurred on the date and hour stated above.

Immediate cause of death
Cardiac Failure
Due to **Auricular Fibrillation**

Due to **Congestive Heart Disease** **3 mos.**
Other conditions **Chronic Bronchitis**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy **117**

Duration

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 **2**

23: Signature **M.H. Kyelland** (M. D. or other) **D.O.**
Address **Liberal, Mo.** Date signed **3-22-46**

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

MOTHER FATHER

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

Signed A. J. Mooneyhan

Licensed Embalmer No. 3616

P. O. Address Areadis, Kans

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. May
Registrar's No. _____

Registration District No. 359

Primary Registration District No. 10220

1. PLACE OF DEATH:

(a) County Vernon
(b) City or town Rural
(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 _____
years, months or days

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME LEWIS J HARTZBEL

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

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____

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 _____ Months _____ Days _____ If less than one day _____ 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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) April 6, 1946 (b) Ruth Hartz

(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above. (Immediate cause of death) _____

Duration _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 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)

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

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

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

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

15485