

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 13 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33392
Registrar's No. 50

Registration District No. 142

Primary Registration District No. 4231

1. PLACE OF DEATH:

(a) County Howell
(b) City or town MOUNTAIN VIEW
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None (Specify whether years, months or days) 38 years

3. (a) PRINT FULL NAME

HENRY W. BARTELS

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex M 5. Color or race W 6. (a) Single, widowed, married 2 divorced Widowed
6. (b) Name of husband or wife MARY BARTELS 6. (c) Age of husband or wife if alive 3 years 1866
7. Birth date of deceased April (Month) 3 (Day) 1866 (Year)

8. AGE: Years 80 Months 6 Days 24 If less than one day hr. min.

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

10. Usual occupation FARMING

11. Industry or business

12. Name CHARLES F. BARTELS 4
13. Birthplace GERMANY (City, town, or county) (State or foreign country)
14. Maiden name CAROLYN HUENEKE
15. Birthplace GERMANY (City, town, or county) (State or foreign country)

16. (a) Informant WALTER BARTELS
(b) Address Mtn. View, Mo
17. (a) BURIAL (b) Date thereof 10-29-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director Joe R. Duncan
(b) Address Mountain View, Mo.
19. (a) 11/8/46 (b) Laura Mitchell
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Howell 4
(c) City or town MOUNTAIN VIEW (If outside city or town limits, write "RURAL")
(d) Street No. 4 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 27 year 1946 hour 9 minute A.M.

21. I hereby certify that I attended the deceased from July 26 1946 to July 26 1946.
that I last saw him alive on July 26 1946.
and that death occurred on the date and hour stated above.
Immediate cause of death Congestive Heart Failure Duration

Due to Banner
Due to

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

Major findings:
Of operations ADDIT
Of autopsy SUPPLEMENTARY INFORMATION
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in REQUIRED
(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) (e) Means of injury 2
23. Signature Stanley Banner (M. D. or other) D.O.
Address Mountain View Date signed 11-6-46

M. S.
-f-M
EX 10

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.....

Joe R. Lincum
.....
Licensed Embalmer No. *4325*

P. O. Address *Mountain View 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, fact should be so stated above.

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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *nov*

Registrar's No. *50*

Registration District No. *142*

Primary Registration District No. *4231*

1. PLACE OF DEATH:

(a) County *Hawell*
(b) City or town *Mountain View*
(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)

3. (a) PRINT
FULL NAME

Henry W. Bartels

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 *wid*

6. (b) Name of husband or wife.

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

7. Birth date of deceased *April 1864*
(Month) (Day) (Year)

8. AGE:

Years *40*

Months *6*

Days

If less than one day

hr. min.

9. Birthplace

(City, town, or county)

(State or foreign country) *MO*

10. Usual occupation

11. Industry or business

MOTHER FATHER { 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) (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)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *1946* year *1946* hour *1* minute *15* M.

21. I hereby certify that I attended the deceased from *1946* to *1946*, 19

that I last saw him alive on *April 1864*, 19

and that death occurred on the date and hour stated above.

Immediate cause of death *tuberculosis of the lungs*

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)

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

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

23. Signature *Stanley Barman* (M. D. or other) *DO*

Address *Mountain View* Date signed *1-25-46*

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

32220

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