

7. S. No. 2
DOM-5-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 24 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32150**

Registration District No. **207**

Primary Registration District No. **3056**

Registrar's No. **208**

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

88
6
3

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: 306 So Williams
(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 _____
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. 455 E. Burkhardt
(If rural, give location)

(e) Citizen of foreign country? _____
(Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Ida Mae Bartee

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 W. H. Bartee

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

7. Birth date of deceased June 2nd 1885
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>62</u>	<u>3</u>	<u>10</u>	hr. _____ min. _____

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

10. Usual occupation At home

11. Industry or business _____

MOTHER FATHER

12. Name Robert Y. Todd

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

14. Maiden name Susan Dunningway

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

16. (a) Informant W. H. Bartee

(b) Address Moberly Mo

17. (a) Burial (b) Date thereof 9-14-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Moberly Mo

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

(b) Address Moberly Mo

19. (a) Sept 14-47 (b) Leah McCreary
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 12th
year 1947 hour 7 minute 10 M.

21. I hereby certify that I attended the deceased from July 9, 1947, to Sept. 12, 1947, that I last saw her alive on 12 Sept, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death _____
Pulmonary tuberculosis 1 yr.

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? _____

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

23. Signature J. W. Thompson (M. D. _____)
Address Moberly Mo Date signed 9-14-47

RECEIVED
District Health Officer No. 10
District File Number 447 1281
Date Filed SEP 23 1947

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.....

Licensed Embalmer No.....

P. O. Address.....

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.