

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9235**

FILED APR 14 1953

BIRTH NO. _____ REG. DIST. NO. **82** PRIMARY REG. DIST. NO. **3017** Registrar's No. **43**

1. PLACE OF DEATH a. COUNTY Cooper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Moniteau	
b. CITY (If outside corporate limits, write RURAL and give township) Boonville	c. LENGTH OF STAY (In this place) 5 weeks	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Tipton 0680	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital		d. STREET ADDRESS (If rural, give location) No street numbers	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Caroline	b. (Middle) -	c. (Last) Hartman	(Month) April	(Day) 4	(Year) 1953

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH April, 22, 1864	9. AGE (In years last birthday) 88	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Moniteau County, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
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13a. FATHER'S NAME Bethram Walterschiedt		13b. MOTHER'S MAIDEN NAME No record		14. NAME OF HUSBAND OR WIFE Adam Hartman, Deceased	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME John Hartman (Nephew)		ADDRESS Tipton, Missouri	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebral Thrombosis			5 weeks
ANTECEDENT CAUSES	DUE TO (b) Cerebral arteriosclerosis			unknown
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Arteriosclerotic cardiovascular disease			unknown

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 331X		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR
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22. I hereby certify that I attended the deceased from **Feb 26, 1953**, to **April 4, 1953**, that I last saw the deceased alive on **April 4, 1953**, and that death occurred at **4:20 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE [Signature]		(Degree or title)	23b. ADDRESS Boonville Mo	23c. DATE SIGNED 4-9-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-7-53	24c. NAME OF CEMETERY OR CREMATORY Catholic Tipton	24d. LOCATION (City, town, or county) (State) Tipton Missouri	
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DATE REC'D BY LOCAL REG. 4-7-53	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS Tipton, Mo
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(Licensed Embalmer's Statement on Reverse Side)

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

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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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed Jewell-E. Richard
Licensed Embalmer No. 2466

P. O. Address Lipton, 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.