

FILED SEP 4 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26314

STATE FILE NUMBER

Registration District No. 70 Primary Registration District No. 1124 Registrar's No. 58

1. PLACE OF DEATH a. COUNTY <u>Clark</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clark</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kahoka</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kahoka</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>232 College</u>			Length of stay in 1b <u>2 1/2 yrs.</u>		d. STREET ADDRESS <u>232 College</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Essie</u> ^{First} <u>Janie</u> ^{Middle} <u>Bartelmei</u> ^{Last}				4. DATE OF DEATH Month <u>Aug.</u> Day <u>23</u> Year <u>1956</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 28, 1899</u>		9. AGE (In years last birthday) <u>57</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ordained Minister</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Hulbert, Okla.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Thomas Hopkins</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Ann Hoover</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>519-28-6368</u>		17. INFORMANT <u>A. J. Bartelmei</u> Address <u>Kahoka, Mo.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion of Heart.</u>								INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Physically weak.</u>							
		DUE TO (c) <u>Sall bladder trouble.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <u>August 11-56</u> to <u>August 22-56</u> and last saw her ^{her} _{alive} on <u>August 22-56</u> . Death occurred at <u>her home</u> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>D. E. Johnson M.D. Chiropractor</u>				22b. ADDRESS <u>304 E. Main St Kahoka, Mo</u>				22c. DATE SIGNED <u>Aug 25-56</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Aug. 28, 1956</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Broken Arrow, Okla.</u>			
24. FUNERAL DIRECTOR <u>Chas L. Suttner Kahoka Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>8-25-56</u>		26. REGISTRAR'S SIGNATURE <u>J. M. ...</u>			

(Licensed Embalmer's Statement on Reverse Side)

Health,
& Welfare
Public
Service300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Chas L. Lutting*.....

Licensed Embalmer No. *290*.....

P. O. Address *Lucas*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.