

FILED NOV 24 1948

State File No. ....

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 329

1. PLACE OF DEATH:

(a) County Callaway  
 (b) City or town Fulton Mo  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
810 Walnut Street 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 5 weeks  
 years, months or days)

3. (a) PRINT FULL NAME Bertha Care

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

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

6. (b) Name of husband or wife Leornie Care 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased Sept 20 1880  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
68 1 13 hr. min.

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

10. Usual occupation House WfE

11. Industry or business \_\_\_\_\_

MOTHER FATHER {  
 12. Name Charles Bartley  
 13. Birthplace Callaway Co Mo  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Alice  
 15. Birthplace Callaway Co Mo  
 (City, town, or county) (State or foreign country)

16. (a) Informant Leornie Care  
 (b) Address 810 Walnut St Fulton Mo

17. (a) Burial (b) Date thereof Nov 15-1948  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oakley Cemetery Fulton Mo

18. (a) Signature of funeral director Halt Clayton  
 (b) Address New Bloomfield Mo

19. (a) 11-16-48 (b) Josie Mousink  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Callaway  
 (c) City or town 810 Walnut St Fulton Mo  
 (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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov - day 13  
 year 1948 hour 1 minute 45 P.M.

21. I hereby certify that I attended the deceased from Oct 1, 1948 to Death, 1948  
 that I last saw her alive on Nov 12, 1948  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage  
 Duration 1 day

Due to arteriosclerosis

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 83a  
 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? \_\_\_\_\_

23. Signature John J. Brown (M. D. or other) MD  
 Address Fulton Date signed 11-16-48

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

RECEIVED  
DISTRICT HEALTH DEPARTMENT, DISTRICT NO. 9,  
DATE FILED NOV 23 1948

NOV 24 1948

**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 LeRoy Claypool  
Licensed Embalmer No. 4412  
P. O. Address New Bloomfield

**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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(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

Bertha Cawl

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

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Sept 20 (Month) (Day) (Year)

8. AGE: Years 68 Months 1 Days mo (Less than one day) hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Nov. 16 - 1948 (b) Josie Mosekoff  
(Date received local registrar) (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 \_\_\_\_\_ Year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) (c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-35799