

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25422

FILED AUG 5 1957

State, File No. 31
REGISTRAR'S No. 31

BIRTH NO. _____ REG. DIST. NO. 212 PRIMARY REG. DIST. NO. 4326

1. PLACE OF DEATH a. COUNTY MILLER		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY MILLER	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN OLEAN		c. CITY OR TOWN OLEAN	
c. LENGTH OF STAY (In this place) lifetime		d. Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION OLEAN		e. STREET ADDRESS (If rural, give location) OLEAN 06610	

3. NAME OF DECEASED (Type or Print) PERLINA	a. (First)	b. (Middle)	c. (Last) BARTSCH	4. DATE OF DEATH MAY 30 1957	(Month) (Day) (Year)
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH 10 Nov. 1884	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OPERATOR	10b. KIND OF BUSINESS OR INDUSTRY Telephone	11. BIRTHPLACE (City and State or Foreign Country) Moniteau - Co - Mo	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME MINOR - FARRIS	13b. MOTHER'S MAIDEN NAME MANLA - WINGET	14. NAME OF HUSBAND OR WIFE WILLIAM - BARTSCH
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME MRS. WADDE-CRUM	ADDRESS OLEAN Mo
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 3 minutes
	ANTECEDENT CAUSES As for conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION NONE	19b. MAJOR FINDINGS OF OPERATION NONE	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) NONE	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NONE	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) NONE Tusculum - Mo
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21d. TIME OF INJURY NONE	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? NONE
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 10:35 Am., from the causes and on the date stated above.

23a. SIGNATURE L. S. Humphreys D.O. Coron	23b. ADDRESS Tusculum - Mo	23c. DATE SIGNED 30 MAY 57
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 2 June 57	24c. NAME OF CEMETERY OR CREMATORY OLEAN	24d. LOCATION (City, town, or county) (State) OLEAN Mo
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DATE REC'D BY LOCAL REG. MAY 30 57	REGISTRAR'S SIGNATURE Cleo Berretta	25. FUNERAL DIRECTOR'S SIGNATURE Keith M Kaye	ADDRESS ELDON Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

JUL 30 '57

Miller County
Health Department

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 *Keith M. Kays*
Licensed Embalmer No. *399*

P. O. Address *Eldon*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.