

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED JUL 8 1959 157

59-021914

STATE FILE NUMBER

Registration District No. 157 Primary Registration District No. 2028 Registrar's No. 132

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY Jasper		b. CITY (If outside corporate limits, give TOWNSHIP only) Carthage		a. STATE Missouri		b. COUNTY Jasper	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1803 S. Main St		Length of stay in 1b 24 yrs		c. CITY OR TOWN Carthage		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 1002 S. Garrison		(If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First NELLE		Middle EARL		Last BARTLETT		Month Day Year June 24, 1959	
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-21-1867	9. AGE (last birthday) 92	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (City and state or country) Springfield, Mo		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Benjamin Fay		13b. MOTHER'S MAIDEN NAME Kate Norton		14. NAME OF HUSBAND OR WIFE Chas. R. Bartlett			
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 Mrs. W.E. Bailey, 1002 S. Garrison			
Address Carthage, Mo		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) General circulatory failure		DUE TO (b) Arteriosclerotic heart disease				INTERVAL BETWEEN ONSET AND DEATH months	
DUE TO (c)		DUE TO (b) Arteriosclerotic heart disease				years	
DUE TO (c)		DUE TO (b) Arteriosclerotic heart disease				years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Comminuted intertrochanteric fracture of right hip		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		December 1953			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 a.m. p.m. Month, Day, Year	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 12/12/53 to 6-24-59 and last saw her him alive on 6/20/59		Death occurred at 6:20 p on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>E. J. Knell</i> (Degree or title)		22b. ADDRESS MD Carthage, Mo		22c. DATE SIGNED 6-25-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 6-26-59	23c. NAME OF CEMETERY OR CREMATORY Park Cemetery		23d. LOCATION (City, town, or county) (State) Carthage, Mo			
24. FUNERAL DIRECTOR Knell Mortuary, Carthage, Mo		ADDRESS		25. DATE RECD. BY LOCAL REG. 6-26-59		26. REGISTRAR'S SIGNATURE <i>W. J. Clinton</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

O. L. Isbell

Licensed Embalmer No. 4970

P. O. Address Carthage, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.