No. 2
1—2-43
5-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 1? 1945

Registration District No. 1

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 16234

Primary Registration District No. 5068

Registrar's No. 42

1. PLACE OF DEATH:
(a) County ~~Barton~~ Barton
(b) City or town Rural Dayls port Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: N/
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ~~[illegible]~~ (Specify whether years, months or days)
In this community 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Barton "
(c) City or town Rural "
(If outside city or town limits, write "RURAL")
(d) Street No. Dayls port Township "
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME AMANDA CATHERINE BARTLETT
3. (b) If veteran, name war No
3. (c) Social Security No. No

4. Sex Female
5. Color or race W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife F. M. Bartlett
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased July (Month) 17 (Day) 1850 (Year)

8. AGE: Years 94 | Months 10 | Days 3 | If less than one day ~~[illegible]~~ hr. ~~[illegible]~~ min.

9. Birthplace unknown (City, town, or county) Tenn (State or foreign country)
10. Usual occupation House wife
11. Industry or business

MOTHER FATHER
12. Name Thomas Cain
13. Birthplace unknown (City, town, or county) Tenn (State or foreign country)

MOTHER
14. Maiden name unknown
15. Birthplace unknown (City, town, or county) " (State or foreign country)

16. (a) Informant Emmet Coward
(b) Address Lamar Mo R#3
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 21 45 (Month) (Day) (Year)
(c) Place: burial or cremation Sheldon Cemetery
18. (a) Signature of funeral director G. B. Berry & Sons
(b) Address Sheldon Mo
19. (a) 5/21/45 (Date received by local registrar) (b) Martha River (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 20
year 1945 hour 3 minute 30 A.M.
21. I hereby certify that I attended the deceased from 3-20-45, 19__, to 5-20, 1945
that I last saw her alive on 5-12, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Senile debility and shock	
Due to Fracture of R femur	
Due to	
Other conditions (Include pregnancy within 3 months of death) ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED	
Major findings: Of operations	
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: No
(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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature W. A. Eggleston (M. D. or other) MD
Address Sheldon Date signed 5-20-45

1179 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 645-698
Date Filed JUN 11 1945

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.....

was not Embalmed, Registered Apprentice No.....,

working under my personal supervision.

Signed Carroll T. Berry

Licensed Embalmer No. 2385

P. O. Address Sheldon 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.

S. No. 2D
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 15 — Primary Registration District No. 5068 — Registrar's No. 42

1. PLACE OF DEATH:
(a) County Barton
(b) City or town Rural
(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)

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

3. (a) PRINT FULL NAME Amanda C. Bartlett
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased July 17 (Month) (Day) 1850 (Year)

8. AGE: Years 94 Months Days If less than one day hr. min.

9. Birthplace (City, town, or county) Tenn (State or foreign country)
10. Usual occupation
11. Industry or business
12. FATHER Name
13. Birthplace (City, town, or county) (State or foreign country)
14. MOTHER Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 20
year 1945 hour p.m. minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

Immediate cause of death — *Duration*
Due to
Due to Fracture of humerus
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy 1460 10

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) accident
(b) Date of occurrence 4-25-45
(c) Where did injury occur? Barton Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
fall in home (farm)
(Specify type of place)
While at work? (e) Means of injury fall

23. Signature Mrs Eglston (M. D. or other) DO
Address Date signed

16234